MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

2375

1. PLACE OF DEATH
County Ripley
Township
City Doniphan (No. ..... St. ..... Ward)
Registration District No. 750
Primary Registration District No. 5985
File No. 9
Registered No. 936

2. FULL NAME Millie Elizabeth Hope.
(a) Residence. No. ..... St., ... Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Jas. M. Hope

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
75	1	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Ripley Co.
(STATE OR COUNTRY) Mo.

PARENTS
10. NAME OF FATHER J. H. Dudley
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) unknown

14. INFORMANT Anderson Hope.
(Address) Doniphan Mo.

15. FILED 1/20, 1930 E. B. Johnston REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-18, 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1930 to Jan 14, 1930 that I last saw her alive on Jan 17, 1930, and that death occurred, on the date stated above, at 2:40 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hemorrage from stomach caused by cancer?
118 C
162 A (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) Senility
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED?
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Black vomit
(Signed) M. B. Waddell, M. D.
1/19, 1930 (Address) Doniphan Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oak Ridge Cem.
DATE OF BURIAL 1-19-1930

20. UNDERTAKER F. E. Jordan, ADDRESS Doniphan, Mo.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County Ripley — Registration District No. 750 — File No.
Township — Primary Registration District No. 4451 — Registered No.
City Doniphan (No. ..... St. ..... Ward)

2. FULL NAME Millie Elizabeth Hope
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Wid

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 10 - 29 - 1854

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
75	1	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 1/20, 1930 E B Johnston REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 18 1930

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY)
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? ..... DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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