

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

Do not use this space.

2434

1. PLACE OF DEATH

County St. Francois
Township St. Francois
City Harrison

Registration District No. 273
Primary Registration District No. 6018A

File No. _____
Registered No. 13
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED, (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 28 - 1849

7. AGE YEARS MONTHS DAYS IT LESS than day, hrs. or min.
80 8- 27

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

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

PARENTS
10. NAME OF FATHER Joseph Davis
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Genesey, Iowa
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Eva Ambreiser
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Genesey, Iowa
(STATE OR COUNTRY)

14. INFORMANT Alfred Proffitt
(Address) Box 200, Harrison, Mo

15. FILED 1-25-1930 T. J. Robinson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 25 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 23, 1929, to Jan 25, 1930 that I last saw her alive on Jan 24, 1930, and that death occurred, on the date stated above, at 1:20 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

atherosclerosis
97 9/18 (duration) yrs. mos. ds.
84 Insanity
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) Paul Hanks, M. D.

Jan. 25, 1930 (Address) Harrison, 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 1002 Elm, Mo. DATE OF BURIAL 1/27/1930

20. UNDERTAKER Needert Mud Co ADDRESS Harrison, Mo

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

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

Dec 14 '86 J