

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

Do not use this space.

4790

MAR 27 1930

1. PLACE OF DEATH
 County Haverhill Registration District No. 3874
 Township West Plains Mo. Primary Registration District No. 4227
 City West Plains Mo. St. _____ Ward _____
 2. FULL NAME Cynthia Ellison Clarke
 (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 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

File No. 28
 Registered No. _____
 St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ed Clarke
 6. DATE OF BIRTH (MONTH, DAY AND YEAR)
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
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 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

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

10. NAME OF FATHER Foyell
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ky.
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Don't know
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY)

14. INFORMANT Tom Ellison
 (Address) West Plains Mo.

15. FILED 2-25-30 OTR. Heurich
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/24-1930
 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 7:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senility Chronic Stomach trouble
46B (duration) _____ yrs. mos. da.
 CONTRIBUTORY (SECONDARY) 162 (duration) _____ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____
 8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) L. H. Faulstich M. D.
2-27-30 (Address) West Plains 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 Lawn DATE OF BURIAL 2-25-1930

20. UNDERTAKER Mrs. Faulstich ADDRESS West Plains 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.

WRITE IN LAUREL, WITH ONE WORD MORE THAN THE PREVIOUS RECORD

233
2

110

SECRET

U.S. DEPARTMENT OF STATE
OFFICE OF THE ASSISTANT SECRETARY FOR
INTELLIGENCE AND SECURITY

SECRET

**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 Howell
Township
City West Plains

Registration District No. 384
Primary Registration District No. 7227

File No. 22
Registered No.
St. Ward

2. FULL NAME

(a) Residence. No. Cynthia Ellison Clarke St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Don't know

7. AGE YEARS 69 MONTHS X DAYS X IF LESS than 1 day, hrs. or min.

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)

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 2-25-30 O. P. Heintz REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/24 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

***THE CAUSE OF DEATH* WAS AS FOLLOWS:**

Serious & Chronic Stomach trouble
Probably cancer
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRIBUTED

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

Information should be carefully supplied. AGE should be EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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