

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

Do not use this space.

4845

485
~~671~~

1. PLACE OF DEATH

County Jackson
Township Blaine
City Marion Mo (No. 6016 1st 1st 1st)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. _____
St. _____ Ward) _____

2. FULL NAME

Abigail Fairley
(a) Residence. No. 6016 E 12 St. 2 Ward.

(If nonresident, give city or town and State)

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 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 John P. Fairley

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 25 - 1838

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	91	4	6	

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

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

10. NAME OF FATHER Geo Wolf

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ohio
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER No record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) No record
(STATE OR COUNTRY)

14. INFORMANT J. A. White
(Address) 6016 E 12

15. FILED 7/23 1930 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Jan 28, 1930 to Feb 1, 1930 that I last saw him alive on Jan 31, 1930, and that death occurred, on the date stated above, at 10:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Uremia - 135
160 152B
120B
(duration) yrs. mos. ds. 5
CONTRIBUTORY (SECONDARY) Enteric Colitis with dysentery - (duration) yrs. mos. ds. 5

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Physical diagnosis

(Signed) K. C. Mellett M. D.

Feb 2, 1930 (Address) 9901 E. 12th St

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt Washington DATE OF BURIAL Feb 3 1930

20. UNDERTAKER Mrs. C. L. Forester ADDRESS K. C. 246

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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920 Angyle Blatz, Vi. 1105

201 Westover Rd. Hi. 2271

Va. 7134

3631 Penn. We. 7925