

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.

APR 28 1930

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

Do not use this space.

8226

1. PLACE OF DEATH  
 County *Linn* Registration District No. *266*  
 Township *Linn* Primary Registration District No. *83149*  
 City *Waverly* St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME *Dilas Givens*  
 (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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

File No. \_\_\_\_\_  
 Registered No. *7798*  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct. 17-1857*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
*78 4 17*

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work *Farmer*  
 (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) *California*

PARENTS

10. NAME OF FATHER *Don't know*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) *Don't know*

12. MAIDEN NAME OF MOTHER *Humes*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) *Inderson Ky*

14. INFORMANT *Wm. Givens* (Address) *Marion Mo.*

15. FILED *3/4* 19*30* *W. E. Rudd* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *3/4* 19*30*

17. I HEREBY CERTIFY, That I attended deceased from *Feb. 15* 19*30*, to *March 4* 19*30* that I last saw him alive on *Nov. 20*, and that death occurred, on the date stated above, at *1* a. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Endocarditis, Chronic*

*92A*  
*11/2* (duration) *2* 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? *None*  
 (Signed) *W. E. Rudd*, M. D.  
 , 19 \_\_\_\_\_ (Address) *Salem, 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 *Empire Cemetery* DATE OF BURIAL *3/5* 19*30*

20. UNDERTAKER *none* ADDRESS \_\_\_\_\_

