APR 28 1930

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

Do not use this space.

8446

1. PLACE OF DEATH
County Harrison — Registration District No. 334 — File No. 555
Township — Primary Registration District No. 4199 — Registered No.
City Bethany (No. ..... St. ..... Ward)

2. FULL NAME Olive Heaston
(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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-28-1869

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
60	5	9	

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) Bethany
(STATE OR COUNTRY) Mo.

PARENTS
10. NAME OF FATHER Wm. C. Heaston
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Do not know
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Gertrude Iroing
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Do not know
(STATE OR COUNTRY)

14. INFORMANT B. S. M. Edwards
(Address) Bethany Mo

15. FILED 4/9 1930 W J Harned REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 7 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 14, 1930, to Mar 7, 1930, that I last saw her alive on Mar 6, 1930, and that death occurred, on the date stated above, at 7.35 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Gastric carcinoma
4 6 B
7 1 B
Six months (duration) ..... yrs. ..... mos. ..... ds.

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

44 A

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? X ray
(Signed) D. G. Reid D.O. ~~M.D.~~
, 19 (Address) Bethany 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 Miriam Cemetery — DATE OF BURIAL 3-9 1930

20. UNDERTAKER S M Haas — ADDRESS Bethany Mo.

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

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.