

X. 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.

PR 30 1930

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

Do not use this space.

9108

1. PLACE OF DEATH

County Jasper Registration District No. 407
 Township Cartersville Primary Registration District No. 4241
 City Cartersville No. _____ St. _____ Ward)

File No. _____
 Registered No. _____

2. FULL NAME

(a) Residence. No. 310 N. Cass St., _____ Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>		4. COLOR OR RACE <u>White</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Will Carlis</u>					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Jan. 24-1881</u>					
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.	
	<u>49</u>	<u>1</u>	<u>19</u>		
8. OCCUPATION OF DECEASED					
(a) Trade, profession, or particular kind of work <u>at Home</u>					
(b) General nature of industry, business, or establishment in which employed (or employer) _____					
(c) Name of employer _____					
9. BIRTHPLACE (CITY OR TOWN) <u>Bedard Co. Mo.</u> (STATE OR COUNTRY)					
PARENTS	10. NAME OF FATHER <u>L. Pitman</u>				
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Ohio</u> (STATE OR COUNTRY)				
	12. MAIDEN NAME OF MOTHER <u>Rachel Ambledon</u>				
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Ohio</u> (STATE OR COUNTRY)				
14. INFORMANT <u>Will Carlis</u> (Address) <u>Cartersville Mo.</u>					
15. FILED <u>3-17 1930</u> <u>C. E. Gray</u> REGISTRAR					

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 16 1930
 17. I HEREBY CERTIFY, That I attended deceased from Mar. 15th, 1930, to Mar. 16, 1930, that I last saw her alive on Mar. 15, 1930, and that death occurred, on the date stated above, at 1:20 P. M.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
9otic
inanimation from psychosis.
 (duration) 1 yrs. mos. ds.
 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) J. W. Clark, M. D.
 (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 Mt. Hope Cem. DATE OF BURIAL 19
 20. UNDERTAKER West City Ind. Co. West City ADDRESS _____

