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

Do not use this space.

1. PLACE OF DEATH
County Clay — Registration District No. 198 — File No. 12041-F
Township Fishing River — Primary Registration District No. 3011 — Registered No. 36
City Excelsior Springs — St. — Ward)

2. FULL NAME Betty Ann McCauts
(a) Residence. No. 62K Canon 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	Colored	✓

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 15 1930

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	✓	✓	✓	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Excelsior Springs
(STATE OR COUNTRY) Mo.

PARENTS
10. NAME OF FATHER Lonzo McCauts
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Alabama
12. MAIDEN NAME OF MOTHER Josephine Murry
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Mo.

14. INFORMANT Mr Longo McCauts
(Address) Excelsior Springs.

15. FILED 4/16, 1930 Y. D. Craven REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 15 1930

17. I HEREBY CERTIFY, That I attended deceased from April 14, 1930, to April 15, 1930 that I last saw her alive on April 14, 1930, and that death occurred, on the date stated above, at 1:30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Failure of closure of Former scale
157C
158 (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) circulation
(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? physical symptoms
(Signed) S. R. McCarthy, M. D.
4/16, 1930 (Address) Excelsior Spgs 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 Elmwood Cemetery — DATE OF BURIAL April 17 1930

20. UNDERTAKER John C. Prather — ADDRESS Ex Springs 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.

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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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.

1. PLACE OF DEATH.
County: Clay — Registration District No.: 198 — File No.:
Township: — Primary Registration District No.: 3011 — Registered No.: 36
City: Excelsior Springs (Name) — St. — Ward)

2. FULL NAME: Betty Ann McCants
(a) Residence. No. — St. — Ward. (If nonresident give city or town and State)
(Usual place of abode)
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: Col
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 4-15-1930

7. AGE — YEARS — MONTHS — DAYS — If LESS than 1 day 20 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)

PARENTS
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 4/15 1930 G. D. Graves
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 4/15 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 ... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Failure Classic
Toxemia ovale
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (SECONDARY): Circulation
(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) ..., 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

SUPPLEMENTARY

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