

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

Do not use this space.

13265

File No. 1-1930
Registered No. 13
St. _____ Ward _____

1. PLACE OF DEATH Wm. Donald
County _____ Registration District No. 578
Township _____ Primary Registration District No. 4574
City Anderson (No. _____) St. _____ Ward _____

2. FULL NAME America Jane Chaney
(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 <u>Female</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widow</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Wm. Matt Chaney</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>17th Mar 1860</u>				
7. AGE	YEARS <u>70</u>	MONTHS <u>X</u>	DAYS <u>18</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____				

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

10. NAME OF FATHER Wm. Lenza Larimore

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

12. MAIDEN NAME OF MOTHER Jane Skaggs

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ky.
(STATE OR COUNTRY)

14. INFORMANT Wm. Chaney
(Address) Anderson Mo.

15. FILED 4/5-30 Wm. Mitchell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 5th 1930

17. I HEREBY CERTIFY, That I attended deceased from 4-3 1930 to 4-5 1930 that I last saw him alive on 4-5 1930 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Sudden Heart Failure
(duration) yrs. mos. ds. _____

CONTRIBUTORY (SECONDARY) 204
(duration) yrs. mos. ds. _____

18. WHERE WAS DISEASE CONTRACTED at Home
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) J. T. Fulkerson M. D.
4/5, 1930 (Address) Anderson 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 <u>Anderson Mo.</u>	DATE OF BURIAL <u>Apr 6 1930</u>
20. UNDERTAKER <u>Geo Latimer Murr Co</u>	ADDRESS <u>Anderson Mo.</u>

K. 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.

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

JUN 26 1930

