JUN 24 1930

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

Do not use this space.

15240

1. PLACE OF DEATH

County Audrain — Registration District No. 26 — File No.

Township Saltriver — Primary Registration District No. 3002 — Registered No. 65

City Mexico Mo (No. ..... St. ..... Ward)

2. FULL NAME Barbara Amanda Coil

(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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan - 27. 1841

7. AGE: Years 89. Months 3 Days 17 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: house wife
(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): Breckinridge Co Ky Kentucky

PARENTS

10. NAME OF FATHER: Joseph Ball
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Virginia.
12. MAIDEN NAME OF MOTHER: Sarah Jolly.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Penn.

14. INFORMANT: Paul E Coil
(Address): Mexico Mo

15. FILED May 15th 1930 Ira S Milligan REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR): May 14 1930

17. I HEREBY CERTIFY, That I attended deceased from May 1 1930, to May 14 1930 that I last saw alive on May 14 1930 and that death occurred, on the date stated above, at 10:10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arterio Sclerosis
Blood clot on speech center
extending cavity. Coma
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): age
(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? clinical

(Signed) Paul E Coil, M. D
, 19 (Address) Mexico 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: Perry Mo — DATE OF BURIAL: May 16th 1930

20. UNDERTAKER: G W Roselle — ADDRESS: Perry Mo

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.

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