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

Do not use this space.

15502

1. PLACE OF DEATH
County Calaway
Township Shamrock
City Wellsville (No. ..... St. ..... Ward)
Registration District No. 116
Primary Registration District No. 5166
File No. 11
Registered No. 11

2. FULL NAME Ad Mary Lail
(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 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widower
5A. ~~IF MARRIED, WIDOWED, OR DIVORCED~~ HUSBAND OF ~~(OR) WIFE OF~~ Ann Lail
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb - 4 - 1837
7. AGE Years 93 Months 3 Days 18 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Farming
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Calaway Co Mo
PARENTS
10. NAME OF FATHER Eliza Lail
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky
12. MAIDEN NAME OF MOTHER Ann Hamilton
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Kentucky
14. INFORMANT Charles Lail
(Address) Martinsburg Mo
15. FILED 6/1, 1930 Mrs. Ethel Armstrong REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 22 1930
17. I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to May 22, 1930 that I last saw h... alive on May 19, 1930, and that death occurred, on the date stated above, at 10:30 a.m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
X2H
97
(duration) ..... yrs. 2 mos. 10 ds.
CONTRIBUTORY (SECONDARY) Arterio Sclerosis
(duration) 15 yrs. ..... mos. ..... ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) U S A Arnold, M. D.
5/30, 1930 (Address) Martinsburg 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 Liberty
DATE OF BURIAL 5-23 1930
20. UNDERTAKER N. B. Wells
ADDRESS Wellsville 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.