

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

Do not use this space.

16345

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township How Primary Registration District No. 1062
 City N. C. Mo. (No. 1029 Park Ave)

File No. 2253
 Registered No. 2253
 St. _____ Ward _____

2. FULL NAME

William Wallace Dwire
 (a) Residence No. 1029 Park St. 9 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Martha Francis
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 5-1857
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
72 11 23
 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Retired
 (b) General nature of industry, business, or establishment in which employed (or employer) 20 years
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Iowa

PARENTS
 10. NAME OF FATHER Jacob Dwire
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) no record
 12. MAIDEN NAME OF MOTHER no record
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) no record

14. INFORMANT Mrs. Geo. Shedden (Address) 1636 Chicago

15. FILED 5/28 1930 M. M. Crodner REGISTRAR
Over

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 28-1930
 17. I HEREBY CERTIFY, That I attended deceased from May 22 to May 28, 1930
 that I last saw him alive on May 28, 1930 and that death occurred, on the date stated above, at 9 AM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
82 A
97 (duration) yrs. mos. ds. _____
 CONTRIBUTORY (SECONDARY) Arterio-sclerosis
 (duration) / yrs. mos. ds. _____

18. WHERE WAS DISEASE CONTRACTED _____
 IS NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? clinical
 (Signed) Frank B. Brown, M. D.
578, 1930 (Address) 804 Argyle

*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 DATE OF BURIAL May 30 30

20. UNDERTAKER Mrs. C. L. Foster ADDRESS N. C. 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.

804 713277
9 120 S. Van Brunt Be. 1610