

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.

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

Do not use this space.

18452

1. PLACE OF DEATH

County North
Township Clatsall
City Grant City (No. 11)

Registration District No. 903
Primary Registration District No. 48745

File No. _____
Registered No. 11
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Mary Jane Williams</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Nov. 24, 1840</u>		
7. AGE <u>89</u>	YEARS <u>6</u>	MONTHS <u>0</u>
		DAYS <u>0</u>
		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) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

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 Mrs. E. J. Alderson
(Address) Grant City, Mo.

15.

FILED 5-24, 1930 John W. Alderson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-24 1930
17. I HEREBY CERTIFY, That I attended deceased from 5-24, 1930 to 5-24, 1930
that I last saw him alive on 5-24, 1930, and that death occurred, on the date stated above, at 11:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:Medical degeneration.92A173(duration) 2 yrs. mos. ds.**CONTRIBUTORY (SECONDARY)**Rheumatism(duration) 5 yrs. mos. ds.**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

DID IN OPERATION PRECEDE DEATH? no DATE OF _____WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

Physical findings(Signed) E. J. Alderson

M. D.

5-24, 1930 (Address) Grant City, 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**DATE OF BURIAL**Omaha, Neb.5-28 1930**20. UNDERTAKER****ADDRESS**Arch C. DuffeeGrant City

