

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

Do not use this space.

19285

File No. 61
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH

County Howell
Township Spring Creek
City _____ (No. _____)

Registration District No. 382
Primary Registration District No. 5539

2. FULL NAME

(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. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Calvin Moore

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Don't know

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
about 70

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) North Carolina

10. NAME OF FATHER David Setzer

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

12. MAIDEN NAME OF MOTHER Selina Sigma

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

14. INFORMANT Dore Williams
(Address) Cureall, Mo

15. FILED 6-21-30 O. A. Heinich
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 20 1930

17. I HEREBY CERTIFY, That I attended deceased from 1:15 to June 20 1930
that I last saw her alive on April 15 1930, and that death occurred, on the date stated above, at 9:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocardial Insufficiency

CONTRIBUTORY (SECONDARY)

92.0 (duration) 9 yrs. mos. da.
90.0 (duration) _____ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) C. C. Beach, M. D.

6-20, 1930 (Address) Elijah M
*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

Cureall

DATE OF BURIAL

6-21 1930

20. UNDERTAKER

Ann Roberts

ADDRESS

Cureall

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.

AUG 26 1930

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