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

Do not use this space.

21672 X

File No. ..... Registered No. .....

1. PLACE OF DEATH

County Texas — Registration District No. 865

Township Cass — Primary Registration District No. 6143

City Elk Creek (No. ..... St. ..... Ward)

2. FULL NAME Clara Ann Hanson

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

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF Willard Hanson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 7 1853

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	76	9	13	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Meadville Pa.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Joshua Ray

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

12. MAIDEN NAME OF MOTHER Rosann Bowersock

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

14. INFORMANT David Hanson
(Address) Elk Creek Mo

15. FILED June 25, 1930 R P Hubbard 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 June 10, 1930, to June 20, 1930 that I last saw her alive on June 15, 1930 and that death occurred, on the date stated above, at 11 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Chronic Nephritis

131

(duration) 1 yrs. 6 mos. ..... ds.

CONTRIBUTORY (SECONDARY) 129A

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH No

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) L W Edens, M. D.

June 21, 1930 (Address) Cabool 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 Freedom — DATE OF BURIAL June 22 1930

20. UNDERTAKER Gaylord Elliott — ADDRESS Cabool

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.