

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

Do not use this space.

22655

1. PLACE OF DEATH

County Holt
Township Clinton
City Mad. City, Mo. (No. _____)

Registration District No. 372
Primary Registration District No. 4218

File No. _____
Registered No. 670
St. _____ Ward _____

2. FULL NAME

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

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED (OR) WIFE OF A. Q. Weber.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 4 1849

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 4 day, hrs. or min.
<u>81</u>		<u>4</u>	<u>2</u>	

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) Ind

10. NAME OF FATHER David M. Davis

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

12. MAIDEN NAME OF MOTHER Nancy Mattox

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) I don't know

14. INFORMANT A. Q. Weber (Address) Madison City Mo.

15. FILED 7-5-30 19 30 REGISTRAR J. O. Fran

MEDICAL CERTIFICATE OF DEATH

2 **16. DATE OF DEATH (MONTH, DAY AND YEAR)** July 6 1930

17. I HEREBY CERTIFY, That I attended deceased from March 10, 1928, to March 21, 1928, that I last saw her alive on March 21, 1928, and that death occurred, on the date stated above, at _____ P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Bronchitis (non tubercular)
935
1062

(duration) 10 yrs. mos. ds.
CONTRIBUTORY Chronic Myocarditis (SECONDARY) (duration) 5 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____ (IF NOT AT PLACE OF BIRTH) _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? W. E. Paul D.O. (Address) Madison 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 Mt Hope DATE OF BURIAL July 8 1930

20. UNDERTAKER W. E. Crawford ADDRESS Madison City 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS IMPORTANT

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