

SEP 25 1930

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

Do not use this space.

23586

1. PLACE OF DEATH

County Miller
Township Saline
City _____ (No. _____)

Registration District No. 561
Primary Registration District No. 5755

File No. _____
Registered No. 58
St. _____ Ward _____

2. FULL NAME

Charity Jane Clay

(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 <u>Female</u>	4. COLOR OR RACE <u>White</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>Wm A Clay</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>July 10 - 1893</u>		
7. AGE <u>97</u>	YEARS <u>97</u>	MONTHS <u>7</u>
	DAYS <u>7</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>None</u> (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) Missouri

PARENTS	10. NAME OF FATHER <u>Boyd Miller</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Kentucky</u>
	12. MAIDEN NAME OF MOTHER <u>Isabel Mully</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Virginia</u>

14. INFORMANT Emma Russell
(Address) Olean, Mo

15. FILED 7-21-30 Belle Haynes REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 17 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 6:45 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Senility
162

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

CONTRIBUTORY (SECONDARY) Age of Subject
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Without Medical Attendance
. 19 (Address) B.H. Registrar

*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 Spring Garden Cem DATE OF BURIAL July 18 1930

20. UNDERTAKER W A Phillips ADDRESS Eldon 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.

