

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

Do not use this space.

27168

**1. PLACE OF DEATH**

County Way  
Township andbolt  
City andbolt (No. ....)

Registration District No. 260  
Primary Registration District No. 0224-a

File No. ....  
Registered No. 65  
St. .... Ward)

**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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 18th 1844

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, .....hrs. or .....min.
<u>86</u>	<u>5</u>	<u>21</u>		

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. House work  
(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) Virginia

10. NAME OF FATHER John Hill

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

12. MAIDEN NAME OF MOTHER Judith Phelan

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

14. INFORMANT Mrs. C. A. Brown  
(Address) Higginville Mo.

15. FILED 9-11, 1930 Bessie P. Porter  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 9 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1926, to Aug 9 1930 that I last saw h. a. alive on Aug 8 1930, and that death occurred, on the date stated above, at 2 2 m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Causes of death  
48 53  
162  
(duration) 2 yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) old age  
(duration) .... yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH. ....

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

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? ....

(Signed) W. C. Webb M. D.

Aug 9, 1930 (Address) Higginville

\*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

Republican Cemetery 9/11 1930

20. UNDERTAKER ADDRESS

W. C. Webb Higginville 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.

56197-916

