

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

Do not use this space.

28984

PLACE OF DEATH

County North Registration District No. 903 File No. _____
 Township Grant City Primary Registration District No. 4840 Registered No. 70
 City _____ St. _____ Ward _____

2. FULL NAME Clara Willison

(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 Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 9 1892

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
92 — 9

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Painter
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

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

10. NAME OF FATHER Geo Willison

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

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Wisconsin
 (STATE OR COUNTRY) Don't know

14. INFORMANT Jode Willison
 (Address) Grant City Mo

15. FILED 8/10 30 John A. Deere
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 18 1930

17. I HEREBY CERTIFY, That I attended deceased from 8-2 to 8-7 1930, and that I last saw him alive on 8-7, 1930, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myastatic pneumonia
accidentary fall + broke hip
at home (duration) yrs. mos. da. 3
 CONTRIBUTORY (SECONDARY) Broken right hip (fracture) (duration) yrs. mos. da. 10

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

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Physiced findings
 (Signed) S. J. Ross, M. D.
8/19 1930 (Address) Grant City Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Grant City Mo DATE OF BURIAL 8-19 1930

20. UNDERTAKER Deere ADDRESS Grant City

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD---
 N. B.—Every item of information 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.

STATE OF TEXAS
COUNTY OF DALLAS

NOTARY PUBLIC
My Comm. Expires

NOTARY PUBLIC
My Comm. Expires

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Worth Registration District No. 903 File No. _____
 Township Grant City Primary Registration District No. 4548 Registered No. _____
 City Grant City (No. _____) St. _____ Ward _____

2. FULL NAME Clark Millison
 (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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of 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) _____

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 18 1930

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Aspirate Pneumonia
Accidentally fell and broke his
hip but would
obvious will

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mo. _____ ds.

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) _____, M. D.
 _____, 19____ (Address)

*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 _____ 19____

20. UNDERTAKER _____ ADDRESS _____

14. INFORMANT (Address) _____

15. FILED Sept 30 John Andrews REGISTRAR

N. B. - Most of information should be carefully checked. AGE should be stated EXACTLY. PHYSICIAN should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
 SHALL NOT RECEIVE A FEE FOR CERTIFICATE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
 REC-11-1-11; WITHOUT CHARGING IN THIS IS A PERMANENT RECORD

SUPPLEMENTARY

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