OCT 28 1930

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

29496

1. PLACE OF DEATH
County Daviess — Registration District No. 248 — File No.
Township Sheridan — Primary Registration District No. 5345 — Registered No. 11
City (No. St. Ward)

2. FULL NAME Amelia Ann McBrayer
(a) Residence. No. St., Ward. (If nonresident, give city or town and State)
(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.

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 HUSBAND OF (OR) WIFE OF: James McBrayer
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sept-17-1855
7. AGE: Years 75 — Months 0 — Days 7 — If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): House Work
(c) Name of employer
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri
PARENTS
10. NAME OF FATHER: Samuel H. Ramsbottom
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): England
12. MAIDEN NAME OF MOTHER: Elmeda Place
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ohio
14. INFORMANT: Lucille P. Martin (Address) Gallatin - Mo.
15. FILED, 19 Mrs Sam Sumter REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept. 24 1930
17. I HEREBY CERTIFY, That I attended deceased from 9/23/30, 19, to 9/23/30, 19, that I last saw her alive on 9/23/30, 19, and that death occurred, on the date stated above, at 8 A. m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralysis of Respiratory Muscle due probably to cerebral
82A Hemorhage
114B (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) (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?
WHAT TEST CONFIRMED DIAGNOSIS? none
(Signed) J. B. Reich, M. D.
9/25/00 (Address) Altamont 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: McCrary Cemetery — DATE OF BURIAL: 9-25 1930
20. UNDERTAKER: H. A. Hope — ADDRESS: Gallatin

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.