OCT 30 1930

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

Do not use this space.

File No. 30452
Registered No. 11

1. PLACE OF DEATH
County: Pemiscot
Township: Medicine
City ..... (No. ..... St. ..... Ward)
Registration District No. 569
Primary Registration District No. 5678

2. FULL NAME Mariella Henrietta Paul

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

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 3 – 1852

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	78	1	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(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 W. L. Downs
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Maland
12. MAIDEN NAME OF MOTHER Martha Jackson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Tennessee

14. INFORMANT Etta Eckert
(Address) Caruthersville Mo R.F.D. #2

15. FILED 9-23-30 O. Morgan
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 22 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 15, 1923, to Sept 22, 1930, that I last saw h. alive on on Sept 21, 1930 and that death occurred, on the date stated above, at 12:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Multiple neuritis
87A
(duration) 7 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? No
WHAT TEST CONFIRMED DIAGNOSIS? None
(Signed) W. H. Musgrove, M. D.
. 19 (Address) Wheeling 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 Olive
DATE OF BURIAL: Sept 24 1930
20. UNDERTAKER: W D Booth
ADDRESS: Charleston 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 A PERMANENT RECORD