OCT 30 1930

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

Do not use this space.

30498

1. PLACE OF DEATH

County Marion — Registration District No. 547 — File No. 237

Township ~~Mason~~ — Primary Registration District No. 3029 — Registered No.

City Hannibal (No. , Levering Hospital St. Ward)

2. FULL NAME Mary Thelma Layne

(a) Residence. No. St., Ward. Center Mo
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Female	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 3-1908

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
22	8	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Teacher 1396 131
(b) General nature of industry, business, or establishment in which employed (or employer) 1090
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Colorado Springs
(STATE OR COUNTRY) Colorado

PARENTS

10. NAME OF FATHER Grover C Layne

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Ralls Co. Missouri

12. MAIDEN NAME OF MOTHER Jessie Irene Williams

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) No Data
(STATE OR COUNTRY) Nebraska

14. INFORMANT Grover C Layne
(Address) Center, Mo

15. FILED 9/10, 1930 [signature] REGISTRAR

5 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 8 1930

17. I HEREBY CERTIFY, That I attended deceased from May 15, 1930 to 9-8, 1930 that I last saw her alive on 9-8, 1930, and that death occurred, on the date stated above, at 3:10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Septicaemia from Pneumococcus Infection Ovarian Abscess
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chronic Nephritis & Pyonephritis (duration) 5 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Center Mo
DID AN OPERATION PRECEDE DEATH? yes DATE OF July 5 1930
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? microscope

(Signed) W. P. Birney M. D.
9-9, 1930 (Address) Hannibal 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: Olivet Center, Mo — DATE OF BURIAL: Sept 10 1930

20. UNDERTAKER: Wm M. Smith — ADDRESS 902 Broadway Hannibal, Mo.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.