OCT 31 1930

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

Do not use this space.

1. PLACE OF DEATH

County Nodaway — Registration District No. 618 — File No. 30641

Township ~~Nodaway~~ — Primary Registration District No. 4369 — Registered No.

City Burlington Jct (No. ..... St. ..... Ward)

2. FULL NAME Betty Jean Wilson

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
F	White	Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 19, 1925

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	5	5	6	

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

9. BIRTHPLACE (CITY OR TOWN) Braddyville
(STATE OR COUNTRY) Iowa

PARENTS

10. NAME OF FATHER: Gomer C. Wilson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Wilcox
(STATE OR COUNTRY) Missouri
12. MAIDEN NAME OF MOTHER: Thelma N. Mann
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Braddyville
(STATE OR COUNTRY) Iowa

14. INFORMANT: Gomer C. Wilson
(Address) Burlington ~~Jct. Mo~~

15. FILED 9/26 19 30 [signature] REGISTRAR
Oct 11-30 C. P. Fryer

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 25th 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 25/30 2 o'clock P.M., 1930, to Sept 25/11 P.M., 1930 that I last saw her alive on Sept. 25th, 1930, and that death occurred, on the date stated above, at Elm. 40 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Inflammation of Stomach and Bowels
Had convulsions during the last hours of her life

1 V B (duration) ..... yrs. ..... mos. 1½ ds.
1 1 8 C
CONTRIBUTORY (SECONDARY) Not known
5 1 B (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH At her home
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Intense Nausea followed with convulsions
(Signed) M. Carter, M. D.
6/26, 19 30 (Address) Burlington Junction 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	DATE OF BURIAL
Braddyville, Iowa	9/27/30 19

20. UNDERTAKER	ADDRESS
J.R. Hann Burlington	Jct. 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.