

NOV 21 1930

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

Do not use this space.

32328

1. PLACE OF DEATH

County Carroll
Township Washington
City Dawn (No. _____)

Registration District No. 138
Primary Registration District No. 5203

File No. _____
Registered No. 34 (Ward _____)

2. FULL NAME

Mally M. Corp

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX fc 4. COLOR OR RACE wh. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 17, 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
71 8 18

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) Ny.

10. NAME OF FATHER Ruban Hatcher

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

12. MAIDEN NAME OF MOTHER Martha Hill.

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

14. INFORMANT Wm B Corp. (Address) Dawn, Mo

15. FILED Oct 10, 19 30 E. H. Messon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 5, 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 25, 1930 to Oct 4, 1930 that I last saw her alive on Oct 4, 1930 and that death occurred, on the date stated above, at 12:45 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Mucous Catarrh
1203

CONTRIBUTORY (SECONDARY) 114B

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

D DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) Dr. B. Hooley, M.D.
Oct 5, 1930 (Address) Braymer 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.

Mt Zion 10-6-1930

20. UNDERTAKER B. F. Mead ADDRESS Mo Braymer.

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.

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