

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.

NOV 26 1930

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

Do not use this space.

33679

1. PLACE OF DEATH

County Oregon
Township Hayward
City Hayward (No. _____)

Registration District No. 632
Primary Registration District No. 7982

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

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

Fe

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

Ed. Dawson

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

Apr - 19 - 1881

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1

49

5

24

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)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Oregon Co. Nev.

10. NAME OF FATHER

James Williams

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Tenn

12. MAIDEN NAME OF MOTHER

Lizzie Lewis

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Tenn

14.

INFORMANT

(Address)

Ed. Dawson

FILED

19. 30

b. Rhea

REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) Oct - 13 1930

17.

I HEREBY CERTIFY, That I attended deceased from May 31 1930 to Oct 13 1930 that I last saw her alive on Oct 11 1930, and that death occurred, on the date stated above, at 4:30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral apoplexy
3 days

82 A

82 B

CONTRIBUTORY (SECONDARY)

Paralysis of left arm & leg

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH?

DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

(Address)

*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

Clifton Cemetery

Oct 14 1930

20. UNDERTAKER

ADDRESS

Carl Hayden

