

UTC 22 1930

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

Do not use this space.

35943

File No. 563  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

1. PLACE OF DEATH

County Harrison Registration District No. 334  
Township Bethany Primary Registration District No. 4497  
City Bethany (No. \_\_\_\_\_)

2. FULL NAME

Wallace W Helton

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M	4. COLOR OR RACE W	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M.		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Nettie Coffey Helton				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-20-1859				
7. AGE	YEARS 71	MONTHS 8	DAYS 29	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Retired Farmer (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)  
Morgan Co. Indiana

10. NAME OF FATHER  
Cecshaw Helton

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

12. MAIDEN NAME OF MOTHER  
Martha Jane Helso

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

14. INFORMANT  
Nettie Coffey Helton  
Bethany Mo

15. FILED 11/10/30  
H. H. Harner  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-19 1930

17. I HEREBY CERTIFY, That I attended deceased from 11/15 1930, to 11/19 1930, and that I last saw him alive on 11/19 1930, and that death occurred, on the date stated above, at \_\_\_\_\_ A. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Angina Pectoris

94A (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

20. WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) H. H. Harner, M. D.  
11/19 1930 (Address) Bethany 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  
Physician Cemetery  
DATE OF BURIAL  
11-21 1930

20. UNDERTAKER  
S. W. H. H. Harner  
ADDRESS  
Bethany 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.

RECORD THIS IS A PERMANENT RECORD

