DEC 22 1930

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

Do not use this space.

36878

File No. 23

Registered No. 23

1. PLACE OF DEATH

County Montgomery

Township Wright Center

City Wellsville (No. ..... St. ..... Ward)

Registration District No. 595

Primary Registration District No. 5797

2. FULL NAME Mary Ann Cotton

(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 2 yrs. 10 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	widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 1-1854

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
76	1854	Dec	5	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Cabin Creek
(STATE OR COUNTRY) Ky.

PARENTS

10. NAME OF FATHER Andrew Morgan

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't Know
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Don't Know
(STATE OR COUNTRY)

14. INFORMANT L H Mueller
(Address) Wellsville Mo

15. FILED Nov 5, 1930 Mrs O D Prewitt, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 4th 1930

17. I HEREBY CERTIFY, That I attended deceased from March, 1930, to Nov 3, 1930 that I last saw h... alive on Nov 3, 1930, and that death occurred, on the date stated above, at Nov 4 4 pm.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Uraemia (Chronic)
Arteriosclerosis
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chronic nephritis
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) A A Dyarkarsh M.D.

, 19 (Address) Wellsville 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
Wellsville Mo	Nov-5-1930
20. UNDERTAKER	**ADDRESS**
F W Kuhne	Wellsville

N. B.—Every item of information should be given, and every statement should be made as full and explicit as possible. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Statement of OCCUPATION is very important.

13-10-29

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

SUPPLEMENTARY

1. PLACE OF DEATH
County *Montgomery* Registration District No. *595* File No.
Township *Upper Loutre* Primary Registration District No. *5497* Registered No. *23*
City (No. St. Ward)

2. FULL NAME *Mary Anis Cotton*
(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 *F*	4. COLOR OR RACE *W*	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Wid*		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec 5 1854*				
7. AGE	YEARS *75*	MONTHS *10*	DAYS *29*	If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(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)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED *Nov. 15*, 19*30* *Mrs O. D. Prewitt* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Nov 4* 19*30*

17. I HEREBY CERTIFY, That I attended deceased from ...., 19...., to ...., 19....
that I last saw h.... alive on ...., 19...., and that death occurred, on the date stated above, at ....m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:

........(duration)........yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY)
........(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) ...., M. D.
, 19 (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 19

20. UNDERTAKER | ADDRESS

N. B.—[illegible] AGE should [illegible] EXACTLY [illegible] state
CAUSE OF DEATH [illegible] is very important.
REGISTRARS [illegible] FOR CERTIFICATES [illegible] AS PRESCRIBED BY LAW

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