

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

Do not use this space.

37169-B

1. PLACE OF DEATH

County St. Clair Registration District No. 1118
Township Dallas Primary Registration District No. 6010
City (No. _____) _____ St. _____ Ward _____

File No. 6
Registered No. 6

2. FULL NAME

(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 27 1875
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
75 2 9

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) Unknown
(STATE OR COUNTRY)

10. NAME OF FATHER Ed. Ventress

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

12. MAIDEN NAME OF MOTHER E. Burris

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

14. INFORMANT (Address) _____

15. FILED Dec 31, 1938 James T. Suricgood
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 1 1930

17. I HEREBY CERTIFY, That I attended deceased from _____ 1930, to Nov 1, 1930
that I last saw her alive on October 31, 1930, and that death occurred, on the date stated above, at 7:45 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cardio-Vascular-Renal Disease
(duration) 10 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) apoplexy
(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? no

WHAT TEST CONFIRMED DIAGNOSIS? Phys. exam.
(Signed) J. H. Murray, M. D.
, 19 Quincy Mo. (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 Butcher DATE OF BURIAL Nov 4 1930

20. UNDERTAKER H. Luckey ADDRESS Wheatland

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

1931
JAN 22

