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.

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

Do not use this space.

37184

1. PLACE OF DEATH
County St. Francois — Registration District No. 773 — File No.
Township St. Francois O. — Primary Registration District No. 6018 A — Registered No. 153
City Farmington, Mo. (No. ..... St. ..... Ward)

2. FULL NAME Rhoda Durrow
(a) Residence. No. Taskee, Mo. 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. 1 mos. 29 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 Widowed

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	82			

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) Unknown
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Jim Wilson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Nancy Jackson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

14. INFORMANT Hospital Records
(Address) Farmington, Mo.

15. FILED 11-12 1930 B. J. Robinson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 8, 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 10, 1930, to Nov. 8, 1930 that I last saw her alive on Nov. 8, 1930, and that death occurred, on the date stated above, at 12:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arteriosclerosis
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Senility, apoplexy and insanity (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) Ralf Hanks, M. D.
11/5/, 1930 (Address) Farmington 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
Hospital Cemetery	11-12 1930
20. UNDERTAKER	ADDRESS