

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

Do not use this space.

39218

1. PLACE OF DEATH

County Holt
Township Notaway
City (No.) (No.) (No.)

Registration District No. 273
Primary Registration District No. 5025

File No.
Registered No.
St. Ward)

2. FULL NAME

Rachel Napier

(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) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED—HUSBAND OF (OR) WIFE OF Grant Napier

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 9 1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
58 1 28

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) Richland Center
(STATE OR COUNTRY) Wis.

10. NAME OF FATHER James Johnson

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Grant Napier
(Address) Rayon Mo.

15. FILED 12-7-30 St. W. Lewis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

13 16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-6 1930

17. I HEREBY CERTIFY, That I attended deceased from 12-1-30 to Dec-6, 1930, that I last saw her alive on 12-6, 1930, and that death occurred, on the date stated above, at 10:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage

(duration) yrs. mos. ds. 5

CONTRIBUTORY (SECONDARY) Hypertension - Arteriosclerosis
No Facts (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: 174-101

19. DID AN OPERATION PRECEDE DEATH? No DATE OF

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) M. L. Holliday, M. D.

Dec 7 1930 (Address) Fillmore 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
Fillmore Mo. Dec. 8 1930

20. UNDERTAKER ADDRESS
W. W. Cole Fillmore Mo.

K. 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.

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

FILED 12-7-1930

