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

Do not use this space.

39750

1. PLACE OF DEATH
County: Jackson
Township: Washington
City: Lawson Mills (No. ....., ... St. ..... Ward)

Registration District No. 407
Primary Registration District No. 0338

File No. .....
Registered No. 68

JAN 20

2. FULL NAME Eva D Little

(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. 3 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	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug-29-1885

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
45	3	15	

8. OCCUPATION OF DECEASED Instructor in
(a) Trade, profession, or particular kind of work Public Schools
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Mexico
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Thomas M. Little

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

12. MAIDEN NAME OF MOTHER Mary E. Gilpin

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

INFORMANT Dr. Little
(Address) Blue Springs Mo.

FILED 12-13 1930 B.F. Drummond
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/14 1930

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: Cerebral Apoplexy
03 A
97
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Arterio-Sclerosis
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? Home
IF NOT AT PLACE OF DEATH .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ..... M. D.
12/13, 1930 (Address) C E Kenney

*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
Mexico Mo.	Dec-17 1930

20. UNDERTAKER	ADDRESS
Webb & Sons	Blue Springs Mo

FOR BINDING INK—THIS IS A PERMANENT RECORD
Be sure that all items are fully supplied. AGE should be stated EXACTLY. PHYSICIANS should state cause of death properly classified. Exact statement of OCCUPATION is very important.