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

Do not use this space.

41676

1. PLACE OF DEATH
County Saline — Registration District No. 796 — File No.
Township — Primary Registration District No. 3038 — Registered No. 170
City Marshall (No. ..... St. ..... Ward)

JAN 22 1931

2. FULL NAME Billy Catherine Epperson
(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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 28-1929
7. AGE: YEARS — MONTHS: 11 — DAYS: 23 — If LESS than 1 day, ... hrs. or ..... min.
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) (STATE OR COUNTRY) Mo

PARENTS
10. NAME OF FATHER Ernest Epperson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Lizzie Whitworth
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo

14. INFORMANT Ernest Epperson
(Address) Marshall Mo

15. FILED 12-16 1930 Mrs. John H. McGuire REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 5 1930
17. I HEREBY CERTIFY, That I attended deceased from Nov 29, 1930 to Dec 5, 1930 that I last saw her alive on Dec 5, 1930 and that death occurred, on the date stated above, at 9-45 a m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
107 A (duration) ..... yrs. ..... mos. 5 ds.
CONTRIBUTORY (SECONDARY) ..... (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) Robert C. Hayner, M. D.
12/5, 19/30 (Address) Marshall

*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: Pleasant Grove Cem — DATE OF BURIAL: Dec 7 1930
20. UNDERTAKER: R. M. Campbell — ADDRESS: Marshall

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
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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County: Saline — Registration District No.: 796 — File No.:
Township: — Primary Registration District No.: 3038 — Registered No.: 170
City: Marshall (No. ..., ..., St. ..., Ward)

2. FULL NAME: Billy Catherine Epperson

(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): S

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

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

7. AGE — YEARS | MONTHS | DAYS | 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 12-16 1930 Mrs. John H McGuire
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 5 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:
Bronchial Pneumonia
There was no measles or whooping cough
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY
(SECONDARY)
(duration) ... yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED: home
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

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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