

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

Do not use this space.

1632165

1. PLACE OF DEATH

County Jackson
Township Paul
City Raussasville

Registration District No. _____
Primary Registration District No. _____

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Bertha Blanch Hawthorn

(a) Residence No. 1655 Washington St. Ward 3
(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 Fe 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 22 1877

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
53 4 8

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer) 235
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Mo
(STATE OR COUNTRY) 1

PARENTS
10. NAME OF FATHER John H. Shelton
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ill
(STATE OR COUNTRY) 2
12. MAIDEN NAME OF MOTHER Emily Ross
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ill
(STATE OR COUNTRY) _____

14. INFORMANT Henry M. Hawthorn
(Address) 1655 Paul

15. FILED 1/31 1931 M. M. Crand
West REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 30 1931

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 to Jan 31, 1931, that I last saw her alive on Jan 28, 1931, and that death occurred, on the date stated above, at _____ a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of Uterus
48

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) 48
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) E. Hooper M. D.

1/30, 1931 (Address) 805 West 17th St

*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

Forest Hill Feb 2, 1931

20. UNDERTAKER ADDRESS

Mrs. C. L. Foster N. P. Mo.

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.

RECORD

