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

Do not use this space.

16792

1. PLACE OF DEATH
County Shannon — Registration District No. 687 — File No. 2
Township Jackson — Primary Registration District No. 6084 — Registered No.
City (No. St. Ward)

2. FULL NAME Lidia E. Mailes
(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.

MAY 27 1931

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. ~~SINGLE, MARRIED~~, WIDOWED ~~OR DIVORCED~~ (*write* the word) Widow
5A. ~~IF MARRIED~~, WIDOWED, ~~OR DIVORCED~~ ~~HUSBAND OF~~ (OR) ~~WIFE OF~~ John E. Mailes
6. DATE OF BIRTH (MONTH, DAY AND YEAR)
7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
60	11	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) House work
(c) Name of employer Self
9. BIRTHPLACE (CITY OR TOWN) Memphis
(STATE OR COUNTRY) Mo.

PARENTS
10. NAME OF FATHER Phillip Barr
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Va.
12. MAIDEN NAME OF MOTHER Lidia A. Wethington
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Dont Know

14. INFORMANT John Mailes
(Address) Rector, Mo.
15. FILED 4/18, 1931 Bess I. Coley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 1st 1931
17. I HEREBY CERTIFY, That I attended deceased from Mch. 27, 1931, to Apr. 1st, 1931, that I last saw her alive on Apr. 1st, 1931, and that death occurred, on the date stated above, at 10 P. m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Influenza
11B
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (SECONDARY) 11B
(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? Usual Physical
(Signed) W. E. Rudd M. D.
, 19 (Address) Salem, 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 Weese Cemetary — DATE OF BURIAL April 3 1931
20. UNDERTAKER Roy Weese — ADDRESS Sinkin Mo.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County: Shannon — Registration District No. 632 — File No.

Township: Jackson — Primary Registration District No. 6484 — Registered No. 5

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Lidia E. Mailes

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	W	Wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 30 1871

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	11	3	

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 COUNTY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTY)

14. INFORMANT .....
(Address)

15. FILED 4/18, 1931. Mrs Clem Wooley
By Clark Wooley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 1 - 1931

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:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (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) ....., 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

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

CAUSE OF DEATH in plain terms, so that it may ... operly classified. Exact statement of OCCUPATION is very important.

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