

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

Do not use this space.

18763

1. PLACE OF DEATH

702 County New Madrid
Township 11 11 11
City Marion (No. _____)

Registration District No. 604
Primary Registration District No. 5802

File No. 40
Registered No. _____
St. _____ Ward _____

2. FULL NAME Vera Wilderess

(a) Residence, No. _____ St. _____ Ward _____
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Caucasian 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
6A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF Peter Wilderess

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1909
7. AGE YEARS 22 MONTHS Est DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. 2 1/2
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Madrid

FATHER 13. NAME Henry Coffee

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Madrid

MOTHER 15. MAIDEN NAME Jessie Coffee

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Madrid

17. INFORMANT (ADDRESS) George Towns

18. BURIAL, CREMATION, OR REMOVAL PLACE Parrott Cemetery DATE May 8 1931

19. UNDERTAKER (ADDRESS) Tichards and Co

20. FILED 5/11/31, 19 1931 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 8 1931

22. I HEREBY CERTIFY, That I attended deceased from May 7, 1931, to May 8, 1931. I last saw him alive on May 7, 1931. Death is said to have occurred on the date stated above at 2 a m.

The principal cause of death and related causes of importance were as follows:
Acute Myocarditis Date of onset _____

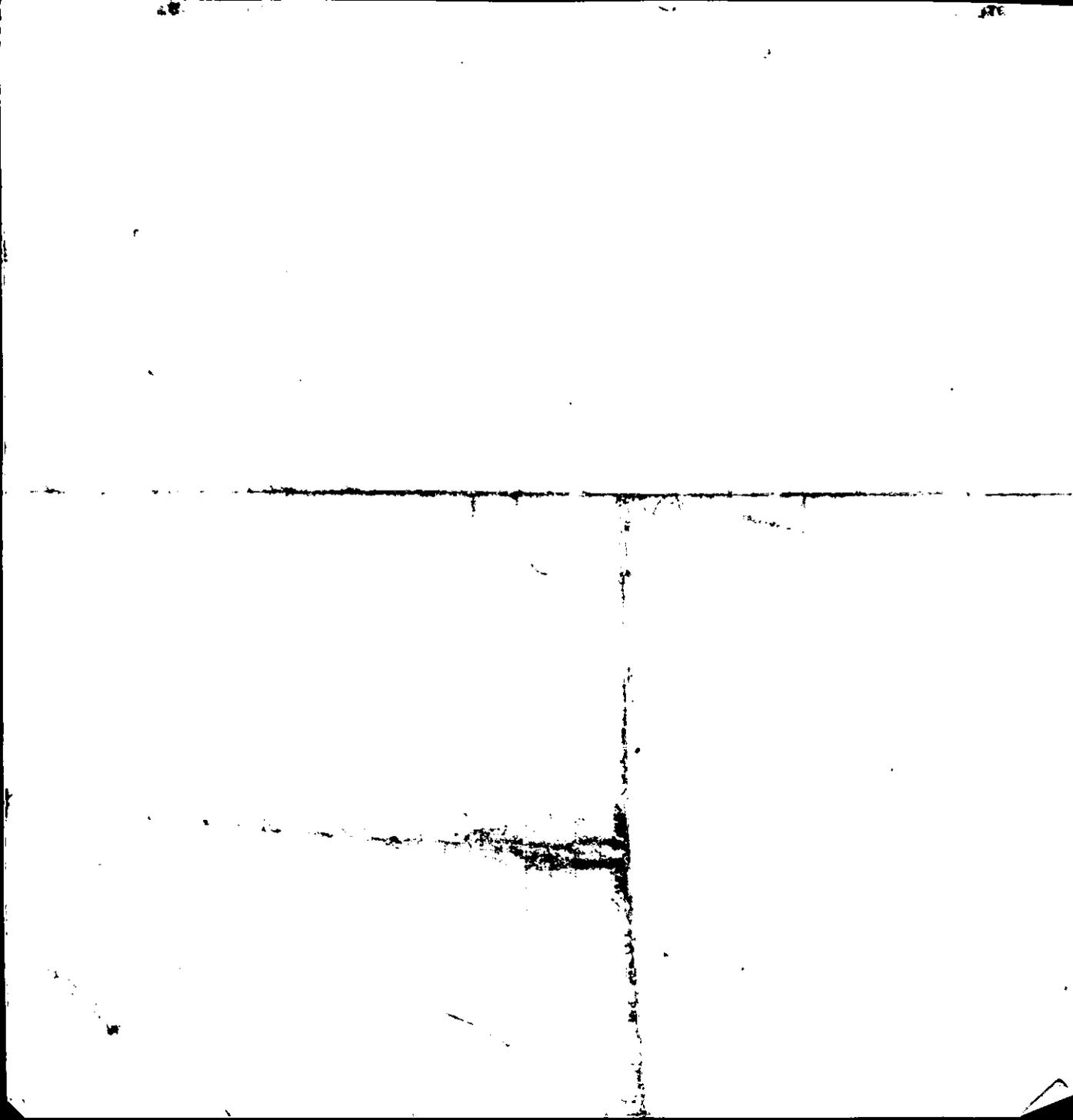
Other contributory causes of importance: _____

Name of operation _____ Date of _____
What test confirmed diagnosis? Autopsy Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) W. D. Dyer, M. D.
(Address) New Madrid, Mo



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County New Madrid Registration District No. 604 File No.
 Township 1 1 1 Primary Registration District No. 1802 Registered No. 40
 City..... (No.) St. Ward)

2. FULL NAME Vera Willness

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

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)

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 6/5/31 M. J. Gunnar REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 8 1931

17. I HEREBY CERTIFY That I attended deceased from to
 that I last saw h. alive 19....., and that death occurred, on the date stated above, at

THE CAUSE OF DEATH WAS AS FOLLOWS:

Acute Nephritis
due to - primary
(acute infection trails)
 (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

20. UNDERTAKER ADDRESS

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

SUPPLEMENTARY 130

S-18763