

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

Do not use this space.

1. PLACE OF DEATH

County Shelby
Township North River
City _____ (No. _____) _____ St. _____ Ward _____

Registration District No. 831
Primary Registration District No. 6093

File No. 30280
Registered No. _____

2. FULL NAME

Bessie Holtshouser

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 1 1885

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
46 | 3 | 7

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(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) Shelby Co. Mo.

10. NAME OF FATHER James Smith

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Kansas

12. MAIDEN NAME OF MOTHER Evelyn Taylor

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Buchanan Co. Mo.

14. INFORMANT (Address) Mrs Wm Foc Radey
Shelbina Mo

15. FILED Aug 9 1931 Emmett A. Howerton
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY That I attended deceased from July 6, 1931, to Aug 8, 1931
that I last saw her alive on Aug 8, 1931, and that death occurred, on the date stated above, at 4-40 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS
Cancer of Liver

46 (duration) yrs. mos. da.
CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. da.

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

0 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? _____ (Signed) [Signature], M. D.
, 19 (Address) Shelbyville, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Everly Cemetery DATE OF BURIAL Aug 7 1931
ADDRESS _____

20. UNDERTAKER JW Thompson Shelbyville 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.

SEP 28 1931

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