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

33205

1. PLACE OF DEATH
County: Pike
Township: Clarence
City: (No. ..., ..., St. ..., Ward)
Registration District No.: 684
Primary Registration District No.: 4408
File No.:
Registered No.: 41

2. FULL NAME: Mary A Latimer
(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: 90 yrs. 4 mos. 26 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): Widow

5a. IF MARRIED, WIDOWED, OR DIVORCED
~~HUSBAND~~ OF (OR) WIFE OF: Henry L Latimer (Died.)

6. DATE OF BIRTH (MONTH, DAY AND YEAR): June 1 - 1842

7. AGE: Years 90 | Months 4 | Days 26 | 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): Clarence Township, Pike Co

PARENTS
10. NAME OF FATHER: Joseph O'Bannon
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Va.
12. MAIDEN NAME OF MOTHER: Julia Strother
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Va.

14. INFORMANT: C. L. Latimer
(Address): Frankford Mo

15. FILED: 11/10, 1932 — Wm Summerhayes, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 10/27 1932

17. I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1932, to Oct. 27, 1932, that I last saw her alive on Oct. 25th, 1932, and that death occurred, on the date stated above, at ... p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
(duration) ... yrs. ... mos. 5 ds.
CONTRIBUTORY (SECONDARY): Arterio-sclerosis
(duration) 2 yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Home
DID AN OPERATION PRECEDE DEATH? No. DATE OF ...
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical Findings
(Signed) J. B. Black, M. D.
10/28, 1932 (Address) Bowling Green, 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Concord Cemetery — DATE OF BURIAL: Oct 29 1932
20. UNDERTAKER: W. B. Elmore — ADDRESS:

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.

NOV 28 1932

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

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

2. FULL NAME .....

(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)

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....., 19 .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

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.