

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

Do not use this space.

16227 ¹⁶¹¹⁰ ~~16227~~ ^{MR} ₇₂
 File No. _____
 Registered No. 28
 St. _____ Ward)

309
 Registration District No. _____
 Primary Registration District No. 6427

1. PLACE OF DEATH

County DeWitt
 Township Athens
 City _____ (No. _____)

2. FULL NAME

Joanna Wiatt

(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 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 W^m W. Wiatt

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 16 - 1846

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
86 7 14

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work none
 (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) Ky.

10. NAME OF FATHER Edward Dale

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

12. MAIDEN NAME OF MOTHER Suscha Wilcott

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Virginia

14. INFORMANT Ira Rice (Address) Albany Mo.

15. May 3, 1933 W. T. Martin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 1 1933

17. I HEREBY CERTIFY, That I attended deceased from April 14, 1933, to April 14, 1933. that I last saw her alive on April 30, 1932, and that death occurred, on the date stated above, at 12 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Coronary Thrombosis
94B (duration) _____ yrs. _____ mos. 15 ds.
 CONTRIBUTORY (SECONDARY) 94B (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? no

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) J. N. Barger, M. D. 5/3 .1933 (Address) Albany 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 Kidwell cemetery DATE OF BURIAL May 2 1933

20. UNDERTAKER A. J. Bane ADDRESS Albany.

K. 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.

JUN 26 1933

PARENTS

