

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

Do not use this space

1. PLACE OF DEATH  
 16 County Cape Registration District No. 124  
 2 Township Boonville Primary Registration District No. 4070  
 2 City Jackson Mo (No. ....) St. .... Ward)  
 2. FULL NAME Barbara Wills  
 (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.

File No. 35876  
 Registered No. ....

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 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 John Wills  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 20 - 1944  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
89 7 11

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) Daisy Mo  
 (STATE OR COUNTRY)

10. NAME OF FATHER Milace Drum  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Daisy Mo  
 (STATE OR COUNTRY)  
 12. MAIDEN NAME OF MOTHER Rosa Sulbough  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Daisy Mo  
 (STATE OR COUNTRY)

14. INFORMANT Gay Cobble  
 (Address) Jackson Mo

15. FILED 11-23 D. G. Leiber  
 19... REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 1, 1933  
 17. I HEREBY CERTIFY, That I attended deceased from Aug 28 .., 1933, to Nov 1 .., 1933, that I last saw her alive on Oct 31 .., 1933, and that death occurred, on the date stated above, at 1 P m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
General Atrophy  
82A  
 (duration) yrs. 2 mos. .... ds.

CONTRIBUTORY (SECONDARY) None  
 (duration) yrs. .... mos. .... ds.

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

0 DID AN OPERATION PRECEDE DEATH? no DATE OF ..  
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS symptoms  
 (Signed) W. S. ..., M. D.  
11-2, 1933 (Address) Jackson 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 New Salem Cemetery DATE OF BURIAL Nov 2 1933

20. UNDERTAKER Craight & Miller ADDRESS Jackson 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.

MISSOURI

