

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

Do not use this space.

1. PLACE OF DEATH

County Pemisscat Registration District No. 654
 Township Halland Primary Registration District No. 6181
 City Halland (No. _____) St. _____ Ward _____

File No. 17624
 Registered No. _____

2. FULL NAME

Ruby Mal Atkinson
 (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 W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Use the word) Child
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF L
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11-26-32
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 6 X

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Huffman Ark

13. NAME P. Atkinson 9.

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark

15. MAIDEN NAME Dial Arnold

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Camden Tenn

17. INFORMANT (ADDRESS) Dial Arnold Halland

18. BURIAL, CREMATION, OR REMOVAL PLACE No 9 - Cem. DATE 5-27-34

19. UNDERTAKER (ADDRESS) German Unit

20. FILED 4-8 1934 Tom Bragance Registrar.

1 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-26-34

22. I HEREBY CERTIFY, That I attended deceased from 24, 1934 to 26, 1934

I last saw him alive on _____ 19____. Death is said

to have occurred on the date stated above, at 6 P m.

The principal cause of death and related causes of importance were as follows:

Calicis Date of onset _____

11919

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

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? If so, specify _____

(Signed) J. B. W. Arnold, M. D.

(Address) Halland 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.

JUN 25 1934

