

DEC 15 1934 MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

39230

1. PLACE OF DEATH *Holt*
County.....*Holt*..... Registration District No. *372*
Township.....*Marion City Mo.*..... Primary Registration District No. *4218*
City.....*Marion City Mo.*..... St. Ward).....
2. FULL NAME *Lydia Wilson*
(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) *Single*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Oct 11 1879*
7. AGE YEAR *55* MONTHS *11* DAYS *17* If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *House work*
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Farber Mo.*
13. NAME *James Wilson*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ky.*
15. MAIDEN NAME *Francis Clements*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Richmond Missouri*
17. INFORMANT *Bertie D. Warr*
(ADDRESS) *Lyoder, Colo.*
18. BURIAL, CREMATION, OR REMOVAL PLACE *Farber* DATE *11/25* 19 *34*
19. UNDERTAKER *W. Campbell*
(ADDRESS) *107 Tracy*
20. FILED *Nov 25 1934* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Nov 22 1934*
I HEREBY CERTIFY, That I attended deceased from *Nov 20* 19 *34* to *Nov 22* 19 *34*
I last saw her alive on *Nov 22* 19 *34* Death is said to have occurred on the date stated above at *4:30* pm.
The principal cause of death and related causes of importance were as follows:
Cerebral hemorrhage Date of onset *11/20/34*
Arterio Sclerosis
Other contributory causes of importance
Name of operation..... Date of.....
What test confirmed diagnosis..... Was there an autopsy? *No*
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? *No*
If so, specify.....
(Signed) *F. E. ...* M. D.
(Address) *Marion City Mo*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

