

MAY 29 1935

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

13445

4

1. PLACE OF DEATH

County Lewis
 Township Lewistown
 City Lewistown (No. _____) St. _____ Ward _____

Registration District No. 481
 Primary Registration District No. 4290

File No. _____
 Registered No. 7

2. FULL NAME

Mary Elizabeth Atherton
 (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) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF George B. Atherton

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 30, 1867
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
67 4 18

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home
 (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) Illinois

10. NAME OF FATHER Horas Ash

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

12. MAIDEN NAME OF MOTHER Lucinda M. Duffy

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

14. INFORMANT Gary B. Atherton
 (Address) Lewistown, Mo

15. FILED 4/19, 1935 J. A. Coder REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 18 19 35

17. I HEREBY CERTIFY That I attended deceased from April 18, 1935, to April 18, 1935, that I last saw him alive on April 18, 1935, and that death occurred, on the date stated above, at 3:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? None

(Signed) Darryl R. M. Crocker
 , 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Union Cemetery
Clark Co. Mo

DATE OF BURIAL

4/20 19 35

20. UMBERTAKER

James A. Coder

ADDRESS

Lewistown 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.

