

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

Do not use this space.

26781

1. PLACE OF DEATH

County Vernon
Township Center
City Nevada (No.)

Registration District No. 875
Primary Registration District No. 3039

File No.
Registered No. 181
St. Ward)

2. FULL NAME

Varleria Gayhart
(a) Residence. No. 258 S Adams St., 7 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. 10 ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX + 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widowed

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 07-18-1843

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>about 86</u>		<u>0-14</u>	<u>00</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Carlisle
(STATE OR COUNTRY) Penn

10. NAME OF FATHER D-12

11. BIRTHPLACE OF FATHER (CITY OR TOWN) D-12
(STATE OR COUNTRY) OK

12. MAIDEN NAME OF MOTHER OK

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

14. INFORMANT (Address) Robert Armstrong Nevada Mo

15. FILED 8-6 1929 E. R. King REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 16, 1929

17. I HEREBY CERTIFY, That I attended deceased from July 5, 1929, to July 16, 1929, that I last saw her alive on July 14, 1929, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral apoplexy
220
99
(duration) yrs. mos. 11, ds.

CONTRIBUTORY (SECONDARY) Arteriosclerosis
heart disease (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? symptoms
(Signed) H. W. Yarnes, M. D.

7-16-1929 (Address) Meranda 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 Topeka Kansas DATE OF BURIAL 7-18-1929

20. UNDERTAKER Very Funeral Home Nevada Mo ADDRESS

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. FILED PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

about 86, 235, 2, 31

