

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

Do not use this space.

29810

1. PLACE OF DEATH

County Madison
Township Castor
City _____ (No. _____)

Registration District No. 837
Primary Registration District No. 6099

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Hattie May Morse

(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 (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
37- 1 14

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Clonngiford, Mo.
(STATE OR COUNTRY) Madison Co.

10. NAME OF FATHER Sam Adams

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

12. MAIDEN NAME OF MOTHER Paula Hunt

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

14. INFORMANT German Morse
(Address) St. Armand, Mo.

15. FILED Sept 27 1929 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 26 - 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1929, to Aug 26, 1929, that I last saw her alive on Aug 25, 1929 and that death occurred, on the date stated above at 12 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Malaria fever
(duration) _____ yrs. _____ mos. 14 ds.

CONTRIBUTORY (SECONDARY) _____
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED Home
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? NO DATE OF _____

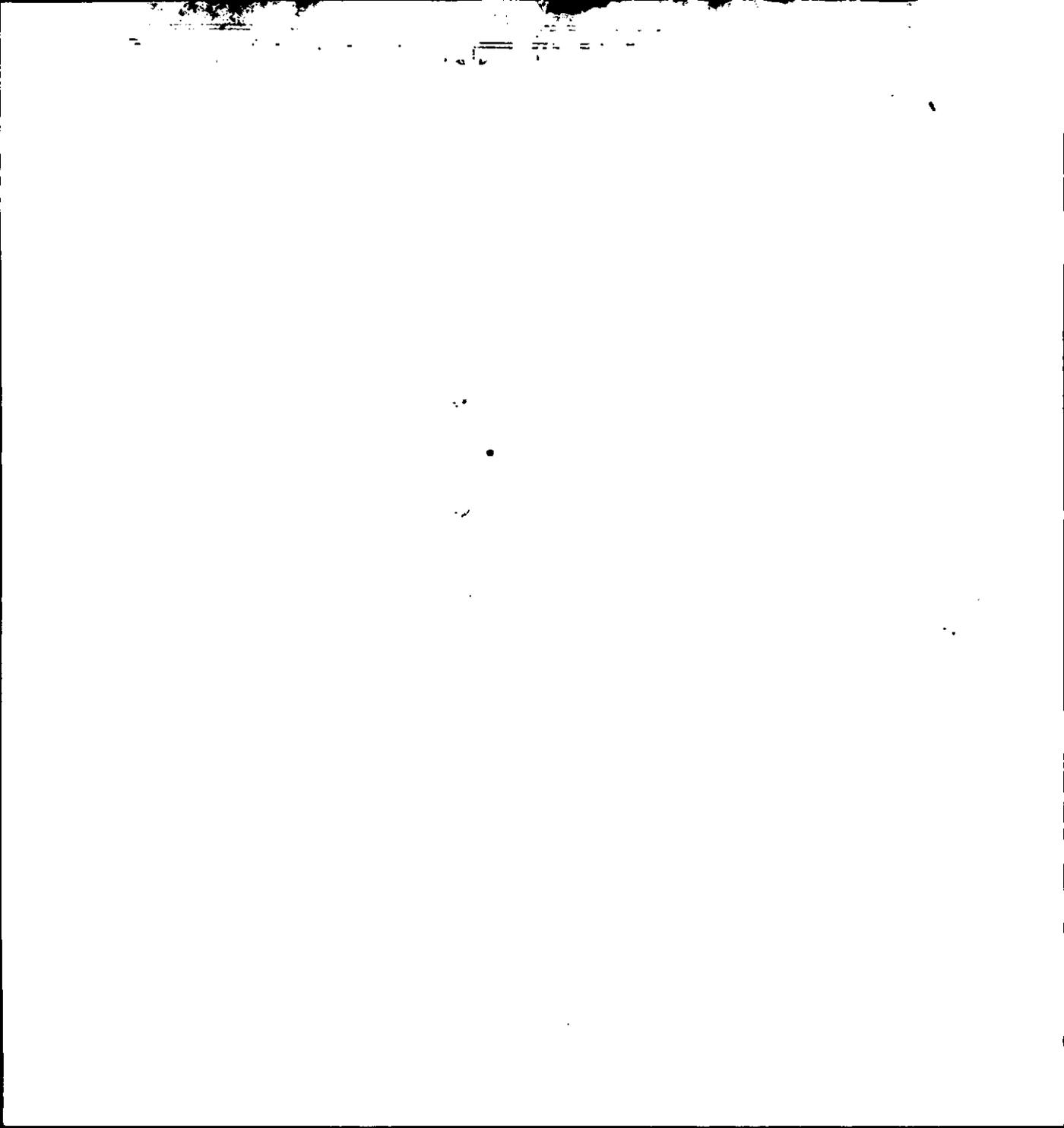
WAS THERE AN AUTOPSY? no.

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) J. P. Beator M. D.
(Address) Emp. 370

*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 Nether Cross DATE OF BURIAL 8-27-1929
ADDRESS Clonngiford Mo.

20. UNDERTAKER A. J. Childs



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