

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

Do not use this space.

18559

1. PLACE OF DEATH

County Bates Registration District No. 54
 Township Rockville Primary Registration District No. 14032
 City Rockville (No. _____) St. _____ Ward _____

2. FULL NAME

Hattie Elmyrath Bellers
 (a) Residence No. Rockville St. 240 Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 15 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>		4. COLOR OR RACE <u>White</u>		5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>G. Beller</u>					
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>1853</u>					
7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.	
<u>76</u>	75	<u>7</u>	<u>3</u>		
8. OCCUPATION OF DECEASED					
(a) Trade, profession, or particular kind of work <u>House wife</u>					
(b) General nature of industry, business, or establishment in which employed (or employer)					
(c) Name of employer					
9. BIRTHPLACE (CITY OR TOWN) <u>Dart Man</u>					
(STATE OR COUNTRY) <u>Missouri</u>					
10. NAME OF FATHER <u>W. B. Parker</u>					
11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Dart Man</u>					
(STATE OR COUNTRY) <u>Dart Man</u>					
12. MAIDEN NAME OF MOTHER <u>Dart Man</u>					
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Dart Man</u>					
(STATE OR COUNTRY)					

PARENTS

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 28 1930
 17. I HEREBY CERTIFY that I attended deceased from _____ 19____
 that I last saw him/her alive on _____ 19____ and that death occurred, on the date stated above, on _____ 19____

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Systolic valvular heart insufficiency
 (duration) _____ yrs. mos. da.
 CONTRIBUTORY age
 (SECONDARY) (duration) _____ yrs. mos. da.

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? _____
 (Signed) H. B. Greenman M. D.
 , 19 (Address) Rockville 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.

14. INFORMANT J. A. Briggs
 (Address) Pittsburg Mo
 15. FILED June 27 1930 Wm. F. B. Freeman
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL W. B. Cemetery DATE OF BURIAL June 24 1930
 20. UNDERTAKER W. A. Walker ADDRESS Rockville

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.

