

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

Do not use this space.

27394

**1. PLACE OF DEATH**

County *New Madrid*  
Township  
City (No. ....) St. .... Ward)

Registration District No. *604*  
Primary Registration District No. *5802*

File No. *67*  
Registered No. ....

**2. FULL NAME**

*Laura Willis*

(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 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

*Female White Widowed*

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

*Sam Willis*

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

*1859*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.

*71*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Wife*  
(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)

*St Genevieve Mo*

10. NAME OF FATHER

*Cubrouster*

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

*Germany*

12. MAIDEN NAME OF MOTHER

*Jane Robinson*

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

*St. Genevieve Mo*

14. INFORMANT (Address)

*J. D. Willis  
Murstow. Mo*

15. FILED 8/8/1931 REGISTRAR

*W. B. Cannon*

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *8-8* 19*30*

17. I HEREBY CERTIFY, That I attended deceased from *8-2* 19*30*, to *8-7* 19*30* that I last saw him alive on *8-7* 19*30*, and that death occurred, on the date stated above, at *11:30 P.M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Coronary failure - mitral - valve lesion - 92 H*

CONTRIBUTORY (SECONDARY) *900* (duration) yrs. mos. ds.

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) *W. L. Duffess* M. D.

, 19 (Address) *New Madrid*

\*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 DATE OF BURIAL  
*New Hope Cem* *8-8* 19*31*

20. UNDERTAKER ADDRESS  
*Richards and Co* *New Madrid*

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.

SEP 9 1930

