OCT 28 1930

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

Do not use this space.

File No. 29548

Registered No. 48

1. PLACE OF DEATH

County Dunklin — Registration District No. 289

Township Cottonhill — Primary Registration District No. 5407

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Infant Died Unnamed

(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)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 8-1930

7. AGE — YEARS — MONTHS — DAYS — If LESS than 1 day, ... hrs. or 10 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(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) Parma Mo.

PARENTS

10. NAME OF FATHER W. H. Fuwell

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

12. MAIDEN NAME OF MOTHER Nora Black

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

14. INFORMANT W. H. Fuwell
(Address) Parma Mo. R2

15. FILED 9-9 1930 ..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 8 1930

17. I HEREBY CERTIFY, That I attended deceased from 9/8, 1930, to 9/8, 1930 that I last saw h..... alive on ....., 19..., and that death occurred, on the date stated above, at 5 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Still born - Asphyxia

1 of D

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Eclampsia.

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) John D Van Clave, M. D.

9/9, 1930 (Address) Malden 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: Malden Mo.

DATE OF BURIAL: 9-9 1930

20. UNDERTAKER: W. L. Craig

ADDRESS: Malden

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.

D.V.