DEC 20 1930

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

Do not use this space.

35504

1. PLACE OF DEATH
County Callaway
Township
City Fulton (No. ..... St. ..... Ward)
Registration District No. 104
Primary Registration District No. 3008
File No.
Registered No. 249

2. FULL NAME Bettie Qualls
(a) Residence. No. Williamsburg Mo 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. 7 mos. 20 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 Neoress Qualls

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

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 Housewife
(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) Ky

PARENTS
10. NAME OF FATHER No information
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) No information
12. MAIDEN NAME OF MOTHER No information
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) No information

14. INFORMANT State Hospital Records
(Address) Fulton Mo

15. FILED Nov 21 1930 R. N. Crews REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov-20- 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept. 25-, 1930, to Nov-19-, 1930 that I last saw her alive on Nov-19-, 1930, and that death occurred, on the date stated above, at 8:00 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arteriosclerosis
97
1288 (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) Enteriosclerosis
..... (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) T. R. Frazer, M. D.
11-20-, 1930 (Address) Fulton State Hospital

*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 Hillcrest Cemetery
DATE OF BURIAL Nov 21 1930
20. UNDERTAKER Leo Wallace
ADDRESS Fulton Mo

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD
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.
V. S. No. 2.

B

B

Name: Bettie Gwallis

Who died at: Fulton, Mo. on Nov. 20, 1930

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex: _____ Color or race: _____ Single, married, widowed or divorced: _____

Date of birth: _____ Age: Years ____ Months _____ Days _____

Occupation: (a) Trade _____ (b) Industry: _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____ NB

Birthplace of mother (State or country) _____

CAUSE OF DEATH: Arteriosclerosis

Contributory: ~~Enteriosclerosis~~

Should be — Acute Enterio-colitis —

Where was disease contracted? _____

Did operation precede death? _____ Date of _____

Was there an autopsy? _____ What test confirmed diagnosis?

S-35504