DEC 29 1930

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

36908
~~36912~~

1. PLACE OF DEATH
County New Madrid — Registration District No. 605 — File No.
Township Como — Primary Registration District No. 5804 — Registered No.
City (No. St. Ward)

2. FULL NAME Goldie Wilson
(a) Residence. No. near Risco 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 2 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): Infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 19-1929

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	11	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) near Risco
(STATE OR COUNTRY) New Madrid Co. Mo

PARENTS
10. NAME OF FATHER Benjamine Wilson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kennett
(STATE OR COUNTRY) Dunklin Co. Mo
12. MAIDEN NAME OF MOTHER Ethel Pankey
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Ill.

14. INFORMANT Benjamine Wilson
(Address) Risco Mo

15. FILED Nov 28 1930 Mrs C. S. Blackman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-25 1930

17. I HEREBY CERTIFY, That I attended deceased from October 20, 1930, to November 25, 1930 that I last saw her alive on Nov. ~~14~~ 14, 1930 and that death occurred, on the date stated above, at 5 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Marasmus

(duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (SECONDARY) Improper Diet

(duration) yrs. 2 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) Homer Beale, M. D
, 19 (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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Parma Cemetery — DATE OF BURIAL: 11-26-1930

20. UNDERTAKER: T C Knight — ADDRESS: Parma

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....

2. FULL NAME .....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and S

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	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)

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

8. OCCUPATION OF DECEASED

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

(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)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT .....
(Address)

15. FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17.

I HEREBY CERTIFY, That I attended deceased from .....,19....., to .....
that I last saw h..... alive on....., 19..
death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....m

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....m

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CA
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SU
HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF F

20. UNDERTAKER	ADDRESS