

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

Do not use this space.

8107

1. PLACE OF DEATH

County Clay
Township Liberty
City Liberty No. _____

Registration District No. 209
Primary Registration District No. 2012

File No. _____
Registered No. 28
St. _____ Ward) _____

2. FULL NAME

(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 <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>Chas. Swader.</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Dec. 20-1870</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>59</u>	<u>2</u>	<u>29</u>	

8. OCCUPATION OF DECEASED

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

(b) General nature of industry, business, or establishment in which employed (or employer). domestic

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Lexington
(STATE OR COUNTRY) Mo

10. NAME OF FATHER Howard Weston

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

12. MAIDEN NAME OF MOTHER Flora Buford

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

14. INFORMANT Chas. Swader
(Address) Liberty, Mo

15. FILED 3/21/30 W. J. Anderson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 19 1930

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
an accident - I having no medical attention as they were all in a boat - and the boat (Holly Rollers) capsized - I must have would say the kind of boat (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Influenza part taken
choking the (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHICH TEST CONFIRMED DIAGNOSIS _____
(Signed) Thos. J. Young Corrow M. D.
3/19 1930 (Address) Liberty Clay Co, 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 Funerary Liberty Mo DATE OF BURIAL 3/20/1930

20. UNDERTAKER Church - Archer Co Liberty Mo ADDRESS _____

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.

APR 28 1930

