

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.

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

Do not use this space.

32113

NOV 19 1935

1. PLACE OF DEATH

County Carroll Registration District No. 134
Township Combs Primary Registration District No. 5189
City _____ (No. _____) St. _____ (Ward _____)

2. FULL NAME

Adah C. Epperson
(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>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (with the word)	
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Newton Epperson</u>			
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>9-29-1883</u>			
7. AGE	YEARS	MONTHS	DAYS
<u>52</u>	<u>—</u>	<u>—</u>	<u>13</u>
			If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>House Keeper</u>		
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		
	10. Date deceased last worked at this occupation (month and year)		
			11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Carroll Co</u>			
FATHER	13. NAME <u>A. S. Cochran</u>		
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Carroll Co</u>		
MOTHER	15. MAIDEN NAME <u>Hattie A. Guillitt</u>		
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Carroll Co</u>		
17. INFORMANT (ADDRESS) <u>A. S. Cochran</u>			
18. BURIAL (CREMATION, OR REMOVAL) PLACE <u>Delephant Cem</u> DATE <u>10/14 1935</u>			
19. UNDERTAKER (ADDRESS) <u>Halls Funeral Home</u>			
20. FILED <u>Oct. 20, 1935</u> <u>Mrs. Ross Brown</u> Registrar.			

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-12-1935

22. I HEREBY CERTIFY, That I attended deceased from 8-23, 1935, to 10-12, 1935.
I last saw him alive on 10-12, 1935. Death is said to have occurred on the date stated above, at 5a m.
The principal cause of death and related causes of importance were as follows:
Metrical Insufficiency Date of onset ?

Other contributory causes of importance:
None ?

Name of operation None Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) W. A. Atwood, M. D.
(Address) Carrollton, Mo

