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

PLACE OF DEATH

County: Butler

Township or Village: Ash Hill

Registration District No. 92 File No. 25 40686

Village or City: Melville

Primary Registration District No. 5134B Registered No.

St.: Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME James Pumnells

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: Dec (Month) 17 (Day) 1882 (Year)

AGE: 29 yrs. 11 mos. 17 d. If LESS than 1 day, hrs. or min.?

OCCUPATION (a) Trade, profession, or particular kind of work: Farmer

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

BIRTHPLACE (City or town, State or foreign country): Pentress Co. Tenn

PARENTS

NAME OF FATHER: Mat Reynolds

BIRTHPLACE OF FATHER (City or town, State or foreign country): Pentress Co. Tenn

MAIDEN NAME OF MOTHER: Dont Know

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Dont Know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Elz S Reynolds

(ADDRESS): Quin Mo

Filed 12/29 1911 Wm Gutzwe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Dec (Month) 28th (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 25th, 1911, to Dec 28th, 1911, that I last saw him alive on Dec 28th, 1911, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows: Gun Shot Wound in the by John Foster Dec 23 63 gon Dec 23 1911

(Duration) yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) W T Russell M. D.

12/29 1911 (Address) Quin Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Melville Cemetery

DATE OF BURIAL: 12/29 1911

UNDERTAKER: None

ADDRESS: None

Revised United States Standard Certificate

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

PLACE OF DEATH

County.....

Township ..... Registration District No..... File No.....

or

Village..... Primary Registration District No..... Registered No.....

or

City .....(NO..... .....St.:.....Ward)

[If death occurre hospital or insti give its NAME i of street and numb

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

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

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

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191...., ...

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 1
(Month) (Day) (

I HEREBY CERTIFY, that I attended deceased

....., 191...., to....., 19

that I last saw h.....alive on....., 19

and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....

(Signed).....

....., 191.... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 19
UNDERTAKER	ADDRESS

Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary