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.

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

12027

PLACE OF DEATH

County Scott

Township Sylvania

or

Village

or

City ~~Oran Mo~~ (NO. , St.: Ward)

Registration District No. 820

Primary Registration District No. 6069

File No. 4 [redacted]

Registered No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Not Married

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: Caucas

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH: 2 (Month) 28 (Day), 1912 (Year)

AGE: yrs. mos. 6 ds.

If LESS than 1 day, 6 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): Oran Mo

PARENTS

NAME OF FATHER: Not known

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

MAIDEN NAME OF MOTHER: Ethel Belt

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. J. Belt

(ADDRESS) Oran Mo

Filed 3/9, 1912. R. C. Glenn, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: 3 (Month) 5 (Day), 1912 (Year)

I HEREBY CERTIFY, that I attended deceased from 2/28, 1912, to 3/5, 1912, that I last saw him alive on 3/5, 1912, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Defective Heart

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) H. S. Winters M. D.

, 191 (Address) Oran, 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: Oran, Mo

DATE OF BURIAL: 3/6, 1912

UNDERTAKER: R. F. Query

ADDRESS: Oran Mo

PLACE OF DEATH

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

County _____

[redacted]

Township _____ Registration District No. _____ File No. _____

or

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

or

City _____ (NO. _____, _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

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.

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH _____ (Month) _____ (Day), 1____ (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 _____ (Month), _____ (Day), 191____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h____ alive on _____, 191____; and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____ (SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*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 _____ DATE OF BURIAL _____, 191____

UNDERTAKER _____ ADDRESS _____