MISSOURI STATE BOARD OF H
BUREAU OF VITAL STATISTIC
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

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

PLACE OF DEATH

County Bates

Township Lone Oak.

or

Village

or

City (NO. , St.: Ward)

Registration District No. 53

Primary Registration District No. 5083

File No. ~~12648~~ 12148

Registered No. 8

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

FULL NAME Walter Hancock

PERSONAL AND STATISTICAL PARTICULARS

SEX male

COLOR OR RACE white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH Feb (Month) 24 (Day), 1882 (Year)

AGE 31 yrs. 1 mos 13 ds.

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) 1 - 0 [illegible]

BIRTHPLACE (City or town, State or foreign country) Pleas Gap Trop Mo

PARENTS

NAME OF FATHER David Hancock

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

MAIDEN NAME OF MOTHER Sarah Willey

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Joe L Beckham (Sister)

(ADDRESS) Butler Mo

Filed Apl 19, 1913. [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April (Month) 18 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from ___, 191__ to ___, 191__, that I last saw him alive on October, 1912, and that death occurred, on the date stated above, at 2:30 m.

The CAUSE OF DEATH* was as follows:

Locomotor Ataxia

6 (Duration) ___ yrs. ___ mos. ___ ds.

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

(Signed) W H Allen M. D.

Apl 19, 1913 (Address) Rich Hill 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 Elliott.

DATE OF BURIAL April 19, 1913

UNDERTAKER M H Carlson Lowe B

ADDRESS Butler Mo

MISSOURI STATE BOARD OF H
BUREAU OF VITAL STATISTIC
CERTIFICATE OF DEATH

PLACE OF DEATH

County

Township
or
Village
or
City (NO. , St.: Ward)

Registration District No. File No.

Primary Registration District No. Registered No.

FULL NAME

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

I HEREBY CERTIFY, that I attended dec
, 191 , to
that I last saw h alive on
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 (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

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

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

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL	DATE OF BU
UNDERTAKER	ADDRESS

Revised United

[Approved by U. S.

Statement of oc

cupation is very imp
fulness of various pu
applies to each and
For many occupation
line will be sufficient,
Compositor, Architect,
Stationary fireman, etc
industrial employmen
kind of work and als
industry, and thereto
the latter statement;
As examples: (*a*) *Sp*
(*b*) *Grocery*; (*a*) *For*
material worked on
ment. Never return
"Dealer," etc., withou
laborer, Farm laborer
at home, who are en
only (not paid *House*
may be entered as *H*
children, not gainfull
Care should be taken
of persons engaged i
and, Cook, Housema
changed or given up
DEATH, state occupa
tired from business,
Farmer (*retired, 6 yr*
pation whatever, wr

Statement of c

DISEASE CAUSING DE
spect to time and
accepted term for t
brosphinal fever (the
cerebrospinal menin
"Croup"); *Typhoid*

of street a
give its
hospital
death if]