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

11270

PLACE OF DEATH

County Shelby

Township Black Creek — Registration District No. 831 — File No.

or Village — Primary Registration District No. 6092 — Registered No. 74 (14)

or City (NO. St.: Ward)

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

FULL NAME Orville Dean Bethards

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

DATE OF BIRTH May 30 (Month), (Day) 1913 (Year)

AGE yrs. 9 mos. 16 ds. — If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work X X
(b) General nature of industry, business, or establishment in which employed (or employer) X X

BIRTHPLACE (City or town, State or foreign country) Malvern, Iowa

PARENTS

NAME OF FATHER Roy Bethards

BIRTHPLACE OF FATHER (City or town, State or foreign country) Shelby Co. Mo

MAIDEN NAME OF MOTHER Bertha Holliday

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy Bethards

(ADDRESS) Shelbyville, Mo.

Filed March 16, 1914 Wm Carson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH March (Month) 16th (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from March 11, 1914, to March 15, 1914, that I last saw him alive on March 16, 1914, and that death occurred, on the date stated above, at 12 40 m.

The CAUSE OF DEATH* was as follows:

Strangulation

1914

A few minutes

(Duration) X yrs. X mos. X ds.

Contributory (SECONDARY) Broncho Pneumonia

(Duration) X yrs. X mos. 8 ds.

(Signed) R. L. Cowden M. D.

March 16, 1914 (Address) Shelbyville 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	DATE OF BURIAL
Shelbyville, Mo. Masonic	March 17, 1914
UNDERTAKER	**ADDRESS**
J. M. Thompson & Son	Shelbyville, Mo.

MISSOURI STATE BOARD OF HEALTH
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 occurred in a hospital or institution, give its NAME instead of street and number]

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

_____, *191*____
(Month) (Day) (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