

PLACE OF DEATH

County Jasper
 Township Madison
 or
 Village
 or
 City (NO. _____ St. _____ Ward _____)

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

39134

Registration District No. 408

File No. _____

Primary Registration District No. 5564Registered No. 179

FULL NAME

John Newton Alexander

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

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

12 12 1970
 (Month) (Day) (Year)

AGE

52 yrs. 11 mos. 12 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)

BIRTHPLACE

(City or town, State or foreign country)

Laclede Co. Mo.

PARENTS

NAME OF FATHER

Geo. E. Alexander

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Madison Co. Tenn.

MAIDEN NAME OF MOTHER

Susan Weatherley

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Bathurstford Co. Tenn.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas L. Alexander(ADDRESS) Dora Mo.Filed Dec 8 1970W. E. Soule

REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

12 7 1970
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from
Dec 7, 1970, to Dec 7, 1970

that I last saw alive on Dec 7, 1970and that death occurred, on the date stated above, at 8:00 a.m.The CAUSE OF DEATH¹ was as follows:Cerebral Hemorrhage82 A
97(Duration) ____ yrs. ____ mos. 8 hrs. ____ ds.Contributory Arterio-sclerosis

(SECONDARY)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. E. Soule M. D.Dec 8 1970 (Address) Carrington 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 ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence.

PLACE OF BURIAL OR REMOVAL

Dudman Cemetery

UNDERTAKER

W. E. Soule

DATE OF BURIAL

12/9 1970

ADDRESS

Carrington Mo.

PLACE OF DEATH

County _____

Township _____

or

Village _____

or

City _____ (NO. _____)

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered 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 (If file the word)
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DATE OF BIRTH _____ (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)

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 _____

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

N. B.—Every statement of information should be carefully given. The cause of death should be stated in plain terms, so that it may be properly classified. Exact statement of cause of death is of great importance. PHYSICIANS should state

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (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) _____ (Address) _____ M. D.

*State the Disease Causing Death, or, in deaths from Violent Cause, 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 _____