

PLACE OF DEATH

County

Laclede

Township

or

Village

or

City

Near Lebanon

Registration District No.

449

File No.

Primary Registration District No.

5609

Registered No.

373

St.

Ward

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

FULL NAME

Grant Archie

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(If write the word)

Married

DATE OF DEATH

Feb

21, 1915
(Month) (Day) (Year)

DATE OF BIRTH

do not know
(Month) (Day) (Year)

AGE

about 35
yrs. mos. 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)

Farm Laborer

BIRTHPLACE

(City or town, State or foreign country)

Chester Co Mo

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)

J M Archie

Lebanon Mo

Mary Alice

Lebanon Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

2/22 1915 J M Bellamy
REGISTRAR

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

65200

MEDICAL CERTIFICATE OF DEATH

I HEREBY CERTIFY, that I attended deceased from

2/20, 1915, to 2/21, 1915,

that I last saw him alive on 2/20, 1915,

and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Tubercular Thrombosis

92A

Contributory

(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) J A McLeod M. D.

2/22 1915 (Address) Lebanon 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

Rolls County

UNDERTAKER

Ross Lickman

DATE OF BURIAL

2/22 1915

ADDRESS

Lebanon

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.

PLACE OF DEATH

County St. Charles

Township St. Charles

or Village St. Charles

or City St. Charles

(NO. 1)

FULL NAME Wm. H. Gordon

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH 1911 (Month) 1 (Day) 1 (Year)

AGE 1 yrs. 0 mos. 0 ds. IF LESS than 1 day, 0 hrs. or 0 min. 0 sec.

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 1911

REGISTRAR

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

Registration District No. 2448

File No. 36

Primary Registration District No. 2448

Registered No. 36

St. St. Charles Ward 1

If death occurred in hospital or in the home, give its NAME of street and number

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH 1911 (Month) 1 (Day) 1 (Year)

I HEREBY CERTIFY, that I attended deceased

that I last saw him alive on 1911, to 1911, and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

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 1911

REGISTRAR

Statement of cause of death.—Name, first, last, and middle, of the person who caused the death, and the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: write None.

For persons who have no occupation whatever, write None.

Contributory (SECONDARY) (Signed) (Duration) yrs. mos. (Duration) yrs. mos. (Address) 1911 (Address) 1911

*State the Disease Causing Death, or, in deaths from Violent Cause, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENT 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 UNDERTAKER ADDRESS

Recommendations on statement of "Contributory." (Recommendations by Committee on Nomenclature of the American Medical Association.)