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

File No. 11478

Registration District No. 15

Primary Registration District No. 50-9

Registered No. 7

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

PLACE OF DEATH

County Andrew

Township Platte

or Village Rea

or City ..... (NO. ..... St.: ..... Ward)

FULL NAME ~~Ho [illegible]~~ Vernon Lusk

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: Wt

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: Apr 27 (Month) (Day), 1915 (Year)

AGE: — yrs. — mos. — ds.

If LESS than 1 day: 5 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): Rea Mo

PARENTS

NAME OF FATHER: Edward B. Lusk

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

MAIDEN NAME OF MOTHER: Nellie E. Tracy

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. E. Jeffries

(ADDRESS) Whitesville

Filed Apr 27, 1915 E. E. Jeffries REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Apr (Month) 27 (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from Apr 27, 1915, to Apr 27, 1915, that I last saw him alive on Apr 27, 1915, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Born at 8 Months
159 / 5 Twin
(Duration) ..... yrs. ..... mos. ..... ds.

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

(Signed) E. E. Jeffries M. D.

Apr 27, 1915 (Address) E. E. Jeffries

*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: Walnut Grove

DATE OF BURIAL: Apr 28, 1915

UNDERTAKER: W. & L. E. Cole

ADDRESS: King City

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

..... (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

....., 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

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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