MARGIN RESERVED FOR BINDING

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

33101

PLACE OF DEATH

County Christian

Township Triplett

or

Village

or

City (NO. St.; Ward)

Registration District No. 177 File No.

Primary Registration District No. 5245 Registered No. 15

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

FULL NAME Odon Guerrero

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: Mexican

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): [illegible]

DATE OF BIRTH: [illegible] (Month) (Day) (Year)

AGE: [illegible] yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Rail Road Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): —

BIRTHPLACE (City or town, State or foreign country): Mexico

PARENTS
- NAME OF FATHER: [illegible]
- BIRTHPLACE OF FATHER (City or town, State or foreign country): [illegible]
- MAIDEN NAME OF MOTHER: [illegible]
- BIRTHPLACE OF MOTHER (City or town, State or foreign country): [illegible]

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charley Clark

(ADDRESS) Snyder

Filed 11/12 1915 C T Collins REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov. (Month) 12 (Day) 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from At Inquest, 191__, that I last saw h__ alive on __, 191__, and that death occurred, on the date stated above, at Dont know at what hr. m.

The CAUSE OF DEATH* was as follows:

Accidentally killed by Railroad Engine

20 M 175-a

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Harry E Tatum M. D.

11/12 1915 (Address) Brunswick 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: Brunswick Mo

DATE OF BURIAL: 11/12 1915

UNDERTAKER: Chas Owens.

ADDRESS: Brunswick 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

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

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