

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

PLACE OF DEATH

County Greene
Township _____
or
Village Sarlington
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 310

File No. 36659

Primary Registration District No. 4186

Registered No. 40

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

FULL NAME George W Bethel

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH

Dec 5, 1856
(Month) (Day) (Year)

AGE

58 yrs. 11 mos. ds.
IF LESS than
1 day, _____ hrs.
or _____ min.?

OCCUPATION:

(a) Trade, profession, or particular kind of work

Stock Shipper

(b) General nature of industry, business, or establishment in which employed (or employer)

Same 2126

BIRTHPLACE

(City or town, State or foreign country)

Alhens Co Ohio 1146

PARENTS

NAME OF FATHER

Geo W Bethel

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Don't know

MAIDEN NAME OF MOTHER

Mahala Erwin

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Don't know

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mattie Bethel

(ADDRESS)

Sarlington Mo

Filed

Dec 18 1915

W. A. Shelby

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

November 5, 1915
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 30, 1915, to Nov 5, 1915, that I last saw him alive on Nov 5, 1915, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Shock hemorrhage from injuries following injury from horse falling on him

accident (Duration) 17 mos. 6 ds.

Contributory (SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

A. L. Hopkins M. D.

8 1915 (Address) Sarlington 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

Sarlington Mo

DATE OF BURIAL

Nov 7, 1915

UNDERTAKER

Ed Allen

ADDRESS

Sarlington Mo

PLACE OF DEATH

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

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.

County _____

Township _____ or _____ File No. _____

Village _____ or _____ Primary Registration District No. _____ Registered No. _____

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) _____, 191____ (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 _____

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____, 191____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw him 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. 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 _____