WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be sure CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County Cape Girardeau

Township Do

or Village

or City Cape Girardeau NO. N Spring St.: 2 Ward)

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

36977

Registration District No. 125 File No.

Primary Registration District No. 3009 Registered No. 1459

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

FULL NAME Henry Bynum

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: Black

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: February (Month) 15 (Day), 1870 (Year)

AGE: 47 yrs. 8 mos. 28 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country): Cape Girardeau Mo

PARENTS

NAME OF FATHER: Berry Bynum

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

MAIDEN NAME OF MOTHER: Sarah Clark

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Bynum

(ADDRESS) Cape Girardeau Mo

Filed 11/14, 1916. R. W. Finnes REGISTRAR

2

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nove (Month) 13 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Nove 9, 1916, to Nov 13, 1916, that I last saw him alive on Nove 9, 1916, and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows: 34

Tuberculosis Of Stomach And Bowels

25 (Duration) about 1 yrs. — mos. ___ ds.

31

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

8 (Signed) R. P. Dalton M. D.

11/14, 1916 (Address) Cape Girardeau

*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: Fairmount Cemetery

DATE OF BURIAL: Nov 14, 1916

UNDERTAKER: Walther F. & U. Co.

ADDRESS: Cape Girardeau 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

..... (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**