LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

C

PLACE OF DEATH

County: Barry County

Township: Liberty

Village:

City: (NO. St.: Ward)

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

Registration District No. 24 File No. 40487-S

Primary Registration District No. 5050 Registered No. 11

FULL NAME: John M. Blue

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Man

4 COLOR OR RACE: White

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

6 DATE OF BIRTH: Dec 31, 1842 (Month) (Day) (Year)

7 AGE: 75 yrs. 1 mos. ds.

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

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

9 BIRTHPLACE (City or town, State or foreign country): Tennessee

PARENTS

10 NAME OF FATHER: James M. Blue

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

12 MAIDEN NAME OF MOTHER: Havell

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Sam M. Blue

(Address): Rocky Comfort

Filed 11/25/ 191[illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 12 (Month) 31 (Day) 1917 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Dec 23, 1917, to Dec 31, 1917, that I last saw ~~home~~ alive on Dec 31, 1917, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

109A Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) D. N. Dabbs M. D.

191 (Address) Rocky Comfort Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 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

19 PLACE OF BURIAL OR REMOVAL: Chilwood Cemetery

DATE OF BURIAL: Jan. 1st, 1918

20 UNDERTAKER: E. F. Sayles.

ADDRESS: Rocky Comfort

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

1 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.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX | 4 COLOR OR RACE | 5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH
..... (Month) ..... (Day) ....., 1..... (Year)

7 AGE
.....yrs.....mos.....ds.
If LESS than 1 day, ...hrs. or .....min.?

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

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
..... (Month) ..... (Day) ....., 191..... (Year)

17 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.

18 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 .....

19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....., 191.....

20 UNDERTAKER | ADDRESS