MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 26724

PLACE OF DEATH

County: Shelby Co

Township: East River
or
Village:
or
City: (NO. St.; Ward)

Registration District No.: 83 File No.: 34

Primary Registration District No.: 6091 Registered No.: ~~2035~~

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

FULL NAME Vernie Magruder

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

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

DATE OF BIRTH: Aug (Month) 1 (Day), 1899 (Year)

AGE: 20 yrs. mos. 26 ds. If LESS than 1 day, hrs. or min.?

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

BIRTHPLACE (City or town, State or foreign country): Shelby Co

PARENTS
NAME OF FATHER: W J Magruder
BIRTHPLACE OF FATHER (City or town, State or foreign country): Monroe Co Mo
MAIDEN NAME OF MOTHER: Mattie V Kidwell
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Shelby Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Samuel A Bush

(ADDRESS) Shelbina Mo

Filed Aug 27, 1919. Mittie Clay REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Aug. (Month) 27 (Day), 1919 (Year)

I HEREBY CERTIFY, that I attended deceased from July 28, 1919, to Aug 27, 1919, that I last saw him alive on Aug 27, 1919, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) 01 yrs. mos. 30 ds.

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

(Signed) J A Furnish M. D.

8/27 1919 (Address) Shelbina Mo

*State (1) 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: Oak Ridge Cem
DATE OF BURIAL: Aug 28 1919
UNDERTAKER: E Hayes
ADDRESS: Shelbina

with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report vague indications, such as "Bowels," "Gastritis," etc. Give date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

MISSOURI STATE BOARD OF HE
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 occ hospital or give its NAM of street and

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 .... (Month) (Day)

I HEREBY CERTIFY, that I attended deceas

........, 191...., to ....

that I last saw h.... alive on ....

and that death occurred, on the date stated above, at....

The CAUSE OF DEATH* was as follows:

.... (Duration) .... yrs. .... mos.

Contributory .... (SECONDARY)

.... (Duration) .... yrs. .... mos.

(Signed) ....

........, 191.... (Address) ....

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

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANS RECENT RESIDENTS)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL	DATE OF BURIA
UNDERTAKER	ADDRESS

No. ....

stered No. ....

.... St. .... W

nt give city or town and State)

irth? yrs. mos.

TE OF DEATH

MAR 1919

I attended deceased from ....

........, 19

........, 19 ....

.... m.

LOWS:

on) .... yrs. .... mos.

on) .... yrs. .... mos.

DATE OF ....

in deaths from VIOLENT CAUSES, st
2) whether ACCIDENTAL, SUICIDAL,
e.)

EMOVAL	DATE OF BURIAL
	ADDRESS

ENTARY.