5276

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

5976

1 PLACE OF DEATH
unty Cedar
wnship
age
Registration District No. 163 File No.
Primary Registration District No. 4095 Registered No. 13
El Dorado Spgs (No. St.; Ward)
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Dennis Caudfield

V. S. No. 2. A

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.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ale
4 COLOR OR RACE: White
5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

E OF BIRTH: Aug (Month) 25 (Day) 1883 (Year)

E: 37 yrs. mos. ds.
If LESS than 1 day, hrs. or min.?

CUPATION (Trade, profession, or ticular kind of work): Carpenter
General nature of industry ness, or establishment in ch employed (or employer):

THPLACE, or town, or foreign country): Mo. Lafex. Mo
10 NAME OF FATHER: Slaughter Campbell
11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Mo
12 MAIDEN NAME OF MOTHER: Emma Cheatum
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo

E ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
formant) L. N. Logan
(Address) El Dorado Spgs Mo

ed 2 4 1920 W. E. Dawson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 6 (Day) 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from June 21 1920 to July 6 1920, that I last saw h[illegible] alive on July 6 1920, and that death occurred, on the date stated above, at 9:30 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia
Lobar
11 A
1920
10
(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Heart
(Duration) yrs. mos. 7 ds.

(Signed) L. N. Logan M. D.
191 (Address) El Dorado Spgs 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: Oak Grove Mo
DATE OF BURIAL: 7-8 1920

20 UNDERTAKER: W. D. Swinn
ADDRESS: El Dorado

V. S. No. 2. A

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.

DO NOT TEAR LEAF OUT

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

1 PLACE OF

County .....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ....., ... St.; ..... Ward)

If death occur hospital or ins give its NAME of street and nu

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.

17 I HEREBY CERTIFY, that I attended deceased
....., 191....., to ....., 19
that I last saw h.....alive on ....., 19
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 Caus
(1) Means of Injury; and (2) whether Accidental, Suicidal or Hom

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Tran or 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 .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 1
20 UNDERTAKER	ADDRESS