LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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.

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

19250

1 PLACE OF DEATH

County Henry

Township or Village or City Clinton Mo (NO. ...... St., ... Ward)

Registration District No. 360

Primary Registration District No. 3018

File No.

Registered No. 135

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

2 FULL NAME William C Gaforth

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
3 SEX: Male 4 COLOR OR RACE: White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word):	16 DATE OF DEATH: May 10 1920 (Month) (Day) (Year)
6 DATE OF BIRTH: June 27 1880 (Month) (Day) (Year)	17 I HEREBY CERTIFY, that I attended deceased from Nov 2, 1919, to May 10, 1920; that I last saw h... alive on May 9, 1920, and that death occurred, on the date stated above, at 3 a. m.
7 AGE: 39 yrs. 10 mos. 21 ds. If LESS than 1 day, ...hrs. or ...min.?	The CAUSE OF DEATH* was as follows: Cirrhosis liver
8 OCCUPATION (a) Trade, profession, or particular kind of work: Mechanic (b) General nature of industry, business, or establishment in which employed (or employer):	124B 13
9 BIRTHPLACE (City or town, State or foreign country): Windsor Missouri	(Duration) ...yrs. ...mos. ...ds.
10 NAME OF FATHER: William P Gaforth	CONTRIBUTORY (Secondary) (Duration) ...yrs. ...mos. ...ds.
11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Ohio	(Signed) D. A. Pog... M. D.
12 MAIDEN NAME OF MOTHER: Miss Cristina Gaforth	6/1, 1920 (Address) Clinton Mo
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ohio	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Cristina Gaforth (Address) Clinton Mo	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
15 Filed 5-11- 1920 ...... Registrar	19 PLACE OF BURIAL OR REMOVAL: Windsor Mo. DATE OF BURIAL: 5-11- 1920 20 UNDERTAKER: ... Clinton. ADDRESS: Clinton Mo

PARENTS

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
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.]

2FULL 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)

.....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

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.