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.

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

28537

PLACE OF DEATH

County Texas Co

Township Clinton

or

Village ~~Mountain Grove~~

or

City _____ (NO. _____ St.: _____ Ward)

Registration District No. 1027 File No. _____

Primary Registration District No. 6136 Registered No. 203

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

FULL NAME Augustis Patrick Papinaw

PERSONAL AND STATISTICAL PARTICULARS

SEX Male

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH Mar 17th, 1846 (Month) (Day) (Year)

AGE 74 yrs. 4 mos. 19 ds.

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

OCCUPATION
(a) Trade, profession, or particular kind of work farm

(b) General nature of industry, business, or establishment in which employed (or employer) 23A

BIRTHPLACE (City or town, State or foreign country) Cherbourg Ontario Kanada

PARENTS

NAME OF FATHER Francis Robert Papinaw

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

MAIDEN NAME OF MOTHER Mary Crowsdell

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. A. P. Papineau

(ADDRESS) Mountain Grove

Filed Aug 11, 1920. J. D. Weatherman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug (Month) 6th (Day), 1920 (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 2, 1920, to Aug 6, 1920, that I last saw him alive on Aug 2, 1920, and that death occurred, on the date stated above, at about 6 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis following Influenza

28

(Duration) 2 yrs. ____ mos. ____ ds.

Contributory (SECONDARY) _____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. M. Hubbard M. D.

8/6, 1920 (Address) Mt Grove Mo

*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 New Cemetery

DATE OF BURIAL 8/7, 1920

UNDERTAKER N. L. Bottles

ADDRESS Mountain Grove

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

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____ (NO. _____ _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[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 _____, 1____ (Month) (Day) (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

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.

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