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.

**PLACE OF DEATH**

County Hickory

Township Stark

or

Village

or

City (NO. St.; Ward)

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

Registration District No. 307 File No. 772

Primary Registration District No. 4-609 Registered No. 1.

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

**FULL NAME** George W. Helms

**PERSONAL AND STATISTICAL PARTICULARS**

| SEX | COLOR OR RACE | SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) |
|---|---|---|
| Male | White | |

DATE OF BIRTH: Oct (Month) 1 (Day), 1870 (Year)

AGE: 50 yrs. 3 mos. 27 ds. If LESS than 1 day, ___ hrs. or ___ min.?

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

BIRTHPLACE (City or town, State or foreign country): Ill

PARENTS
NAME OF FATHER: William Helms
BIRTHPLACE OF FATHER (City or town, State or foreign country): Va.
MAIDEN NAME OF MOTHER: Keziah McCammon
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Va.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Ralph Helms

(ADDRESS) Preston Mo.

Filed Feb 5, 1921 J M Robinson REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

DATE OF DEATH: Jan (Month) 27 (Day), 1921 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 17, 1921, to Jan 19, 1921, that I last saw him alive on Jan 19, 1921, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Cystitis

135B

(Duration) ___ yrs. 3 mos. 20 ds.

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

(Signed) W. S. Woodford M. D.

Jan. 27 1921 (Address) Cross Timbers 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 | DATE OF BURIAL |
|---|---|
| Fisher Cemetery | Jan 28 1921 |
| **UNDERTAKER** | **ADDRESS** |
| A W Boucher | Preston Mo. |

# MISSOURI STATE BOARD OF HEALTH
## 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 occurred in a hospital or institution, give its NAME instead of street and number]

**FULL NAME** _____

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.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD.

## 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), 191_____ (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 |