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

1715

1 PLACE OF DEATH

County Perry

Township Boise Brule — Registration District No. 1128 — File No.

or Village ~~McBride~~ McBride — Primary Registration District No. 5879 A — Registered No. 41

or City (NO. St.; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME No Name

PERSONAL AND STATISTICAL PARTICULARS		
3 SEX: Male	4 COLOR OR RACE: White	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
6 DATE OF BIRTH: Jan (Month) 19 (Day), 1921 (Year)		
7 AGE: yrs. mos. – ds.		If LESS than 1 day, 6 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): McBride Mo		
PARENTS 10 NAME OF FATHER: Charlie Swan		
11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Jackson Co. Ills		
12 MAIDEN NAME OF MOTHER: Mala Burt		
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Perry Co. Mo		

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) McBride Mo

(Address) Clay Swan

15

Filed Jan 20 1921 F. H. Westman

By Alois Staelens Sub- Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 20 (Day), 1921 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan. 19, 1921, to Jan. 20, 1921, that I last saw him alive on Jan. 20, 1921, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Injure from being born

1106 [illegible]

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) 1613

(Duration) yrs. mos. ds.

(Signed) John A Brown M. D.

Jan 20, 1921 (Address) Belgique 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	DATE OF BURIAL
Perryville Mo	Jan 21 1921
20 UNDERTAKER	ADDRESS
Phil Leuckel	Perryville Mo

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.]

2 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.

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

....., 191.....
(Month) (Day) (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