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

1 PLACE OF DEATH

County Shelby

Township Black Creek

or

Village

or

City (NO. , St.; Ward)

Registration District No. 831 File No. 3002

Primary Registration District No. 6092 Registered No. 1

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

2 FULL NAME Perry Chester Claggett

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Jan. (Month) 25 (Day) 1858 (Year)

7 AGE 62 yrs. 11 mos. 13 ds.

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

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

9 BIRTHPLACE (City or town, State or foreign country) Lansing Mich.

PARENTS

10 NAME OF FATHER Jos. B. Claggett

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Tiffin, Ohio

12 MAIDEN NAME OF MOTHER Wilderwood

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Martha Claggett

(Address) Shelbyville, Mo.

15 Filed Jan 10, 1921 Wm Carson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. (Month) 8 (Day) 1921 (Year)

17 I HEREBY CERTIFY, that I attended deceased from March, 1920, to Jan 8, 1921, that I last saw him alive on Jan 8, 1921, and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Heart Block

74 (Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

8 (Duration) yrs. 9 mos. ds.

(Signed) S. H. Manpin M. D.

Jan 9, 1921 (Address) Shelbyville 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 Bethany Cem.

DATE OF BURIAL Jan. 10, 1921

20 UNDERTAKER J. W. Thompson Son

ADDRESS Shelbyville, 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 Shelby

Township Black Creek
or
Village .....
or
City ..... (NO....., ... St.; ..... Ward)

Registration District No. 831

Primary Registration District No. 6882

File No. .....

Registered No. 1

[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

..... (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