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

26592

1 PLACE OF DEATH

County ~~Green~~ Lawrence

Township ~~West Central~~ Ozark

or

Village

or

City (NO. St.; Ward)

Registration District No. 474 File No.

Primary Registration District No. 3658 Registered No.

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

2 FULL NAME Eulysses Theimer

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: April (Month) 8 (Day) 1922 (Year)

7 AGE: 9 yrs. 6 mos. 18 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): Green Co. Mo.

PARENTS

10 NAME OF FATHER: Oscar Theimer

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Howell Co. Mo.

12 MAIDEN NAME OF MOTHER: Manda Hood

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Green Co. Mo.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Max Fartner

(Address) Bois Darc Mo

15 Filed Oct 25 1921 A. V. Clark Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct. (Month) 21 (Day) 1921 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Oct. 19, 1921, to Oct. 21, 1921, that I last saw he alive on Oct. 21, 1921, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

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

CONTRIBUTORY (Secondary) 129

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

(Signed) Leona J. Gunn Morrison M. D.

10-21, 1921 (Address) Halltown 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: John's Chappel

DATE OF BURIAL: Oct. 22, 1921

20 UNDERTAKER: R. S. Johnson

ADDRESS

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) ....., 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