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

9596

PLACE OF DEATH

County Nodaway

Township ~~White Oak~~ Grant

or Village

or City (NO. St.; Ward)

Registration District No. 617

File No. 92

Primary Registration District No. 5819

Registered No.

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

FULL NAME Not Named

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH: Mch (Month) 8 (Day), 1922 (Year)

AGE: yrs. mos. ds.

If LESS than 1 day, 8½ hrs. or min.

OCCUPATION
(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

BIRTHPLACE (City or town, State or foreign country): Bound Mo

PARENTS

NAME OF FATHER: Fred A Jones

BIRTHPLACE OF FATHER (City or town, State or foreign country): Mo

MAIDEN NAME OF MOTHER: Mary L. Craig

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred A Jones

(ADDRESS) Bound Mo

Filed 4/9 1922 J. A. Larrabee REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Mch (Month) 8 (Day), 1922 (Year)

I HEREBY CERTIFY, that I attended deceased from Mch 8, 1922 to Mch 8, 1922, that I last saw him alive on Mch 8, 1922, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

~~Inanition~~ Inanition

158

160

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) M. McCallum M. D.

Mch 8, 1922 (Address) Bound 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: Bethany Cemetery Nodaway Co Mo

DATE OF BURIAL: Mch 9, 1922

UNDERTAKER: None

ADDRESS

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

PLACE OF DEATH

County.....

Township .....
or
Village.....
or
City .....

Registration District No.....

Primary Registration District No.....

File No.....

Registered No.....

(NO. ....., ...St.:.....Ward)

[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

.....(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

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.