LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

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.

1. PLACE OF DEATH
County: Stoddard — Registration District No.: 834 — File No.: 17599
Township: Pike — Primary Registration District No.: 6097A — Registered No.: 9
City: Mesler (No. ..... St. ..... Ward)

2. FULL NAME: Oma Richmond
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): single
6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: ✓
7. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec. 28-1901

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20 ~~19~~	3	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farm Labor
(b) General nature of industry, business, or establishment in which employed (or employer): ✓
(c) Name of employer: ✓
9. BIRTHPLACE (CITY OR TOWN): Mesler
(STATE OR COUNTRY): Mo.
10. NAME OF FATHER: George Richmond
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Mo.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER: Effie Reed
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Illinois
(STATE OR COUNTRY): Ill.
INFORMANT: Charley Carr
(Address): Mesler
FILED: 5/25, 1921 G. E. Lewis, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): May 24 1921
17. I HEREBY CERTIFY, That I attended deceased from May 20th, 1921, to May 24, 1921, that I last saw him alive on May 23, 1921, and that death occurred, on the date stated above, at 11:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Double Broncho Pneumonia (duration) ..... yrs. ..... mos. 6 ds.
CONTRIBUTORY (SECONDARY): measles (duration) ..... yrs. ..... mos. ..... ds.
18. WHERE WAS DISEASE CONTRACTED? ✓
IF NOT AT PLACE OF DEATH? ✓
Did an operation precede death? ✓ Date of ✓
Was there an autopsy? ✓
What test confirmed diagnosis? ✓
(Signed) Asier J. Speer, M. D.
5/25, 1921 (Address) Paintor Mo

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Bell City — DATE OF BURIAL: 5/25 1921
20. UNDERTAKER: John Choicer — ADDRESS: Mesler Mo

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1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No.....

City..... (No....., ...St. .....Ward)

2. FULL NAME.....

(a) Residence. No..... St., ...Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., 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.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed)?....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be [illegible]