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

PLACE OF DEATH

County Henry

Township Springfield

or Village

or City

Registration District No. 352 File No. 26085

Primary Registration District No. 5500 Registered No. 4

(NO. St.; Ward)

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

FULL NAME James Clay Atwell

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

V. S. No. 2.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: April (Month) 22 (Day), 1901 (Year)

AGE: 21 yrs. 5 mos. 21 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country): Missouri

NAME OF FATHER: Roland G Atwell

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

MAIDEN NAME OF MOTHER: Bertha E Thrash

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. K. Weakley

(ADDRESS) Clinton Mo.

Filed 10-2-, 1922 J. P. Allen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Sept (Month) 13 (Day), 1922 (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 25, 1922 to Sept 12, 1922 that I last saw h[illegible] alive on Sept 12, 1922 and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) ____ yrs. 1 mos. 9 ds.

Contributory (Secondary) 01A

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

(Signed) D A Woolard M. D.

Sept 14, 1922 (Address) Calhoun 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: Mt Olive

DATE OF BURIAL: Sept 14, 1922

UNDERTAKER: McButler

ADDRESS: Calhoun Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

PLACE OF DEATH

County _____

Township _____
or
Village _____
or
City _____ (No. _____ St.: _____ Ward) _____

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred i
hospital or institut
give its NAME inst
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) _____ (Ye

I HEREBY CERTIFY, that I attended deceased f
_____, 191___, to _____, 191
that I last saw h_____ alive on _____, 191
and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____ mos.

Contributory _____
(Secondary)

_____ (Duration) _____ yrs. _____ mos.

(Signed) _____ M

_____, 191___ (Address) _____

*State the Disease Causing Death, or in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL _____, 19

UNDERTAKER | ADDRESS