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

PLACE OF DEATH

County ~~Polk~~ ~~Cedar~~ Polk

Township ~~Jefferson~~ Campbell

or

Village ~~Campbell~~

or

City _____ (NO. _____ St.: _____ Ward)

Registration District No. 706 File No. 10147

Primary Registration District No. 5935 Registered No. _____

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

FULL NAME James Dale Cory

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
M	W	Single

DATE OF BIRTH 2 (Month) 28 (Day), 1923 (Year)

AGE _____ yrs. _____ mos. 2 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work None 119
(b) General nature of industry, business, or establishment in which employed (or employer) — 106

BIRTHPLACE (City or town, State or foreign country) Mo.

PARENTS
NAME OF FATHER Willie Cory
BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo.
MAIDEN NAME OF MOTHER Nellie Lewis
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. M. Lewis

(ADDRESS) Dunnigan Mo.

Filed 3/2/ 1923 Geo Engelman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 2 (Month) (Day), 1923 (Year)

I HEREBY CERTIFY, that I attended deceased from 2-28-23, 191__, to 3-2, 1923, that I last saw him alive on Mar 1, 1923, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Catarrhal Bronchitis (and Bowels)

(Duration) _____ yrs. _____ mos. 2 ds.

Contributory (SECONDARY) 3

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

(Signed) C N Hahn M. D.

3-2, 1923 (Address) Hermansville 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 Hermansville Mo

DATE OF BURIAL 3-2, 1923

UNDERTAKER J. W. Lyon

ADDRESS Dunnigan Mo.

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

PLACE OF DEATH

County _____

Township _____ *or* Village _____ *or* City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[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.