LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

15374

LACE OF DEATH

County Caldwell — Registration District No. 99 — File No.

Township Grant — Primary Registration District No. ~~4061~~ 5146 — Registered No. 9

City (No. , St. Ward)

ULL NAME John F Tunnell

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

h 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

X	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
ale	White	Widower

MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

TE OF BIRTH (MONTH, DAY AND YEAR) Feb 14 - 1863

E	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	60	3	8	

CUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer -
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer

RTHPLACE (CITY OR TOWN) Ray Co
(STATE OR COUNTRY) Mo

NAME OF FATHER David Tunnell

BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Tennessee

MAIDEN NAME OF MOTHER Eliza Collock

BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Tennessee

NFORMANT Mrs Maude Mayes
(Address) Polo Mo

ILED May 24/23 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 22 1923

17. I HEREBY CERTIFY, That I attended deceased from May 16, 1923, to May 22, 1923, that I last saw him alive on May 22, 1923, and that death occurred, on the date stated above, at 3:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
100 d (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
None (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? At Home
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) B F Can, M. D
May 23, 1923 (Address) Polo 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	DATE OF BURIAL
Bethel Cemetery Ray Co	May 24 1923
20. UNDERTAKER	ADDRESS
Alspaugh & Cowley	Polo Mo

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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.

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

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

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

City..... (No....., ...St. .....

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.

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)

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to .....,
that I last saw h..... alive on....., 19.....,
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.

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).....

, 19 (Address)

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

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20. UNDERTAKER	ADDRESS

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V. S. No. 2.