LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

27757

LACE OF DEATH

County [illegible]

Township [illegible]

City [illegible] (No. [illegible] St. [illegible] Ward)

Registration District No. 595

Primary Registration District No. 4353

File No. 48

Registered No. 48

ULL NAME [illegible]

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

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

	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
[illegible]	[illegible]	[illegible]

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

TE OF BIRTH (MONTH, DAY AND YEAR) Sept 12 1840

E YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
7	0	23	

CUPATION OF DECEASED

a) Trade, profession, or articular kind of work At Home.

b) General nature of industry, siness, or establishment in hich employed (or employer) Stone.

c) Name of employer

THPLACE (CITY OR TOWN) [illegible]
(STATE OR COUNTRY)

NAME OF FATHER [illegible]

BIRTHPLACE OF FATHER (CITY OR TOWN) [illegible]
(STATE OR COUNTRY)

MAIDEN NAME OF MOTHER [illegible]

BIRTHPLACE OF MOTHER (CITY OR TOWN) [illegible]
(STATE OR COUNTRY) [illegible]

FORMANT [illegible]
address) [illegible]

LED Oct. 20 1923 [illegible]
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from May 7, 1923, to Sept-22, 1923, that I last saw h. alive on Sept-18, 1923, and that death occurred, on the date stated above, at 3 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Apoplexy

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (SECONDARY) Arteriosclerosis

(duration) 1 yr. 2 mos. 13 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? none

(Signed) J. C. Bellamy, M. D

, 19 (Address) Wellsville

*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 [illegible]

DATE OF BURIAL 9-23 1923

20. UNDERTAKER [illegible]

ADDRESS [illegible]

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.)

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

20. UNDERTAKER	ADDRESS