

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

14522

1. PLACE OF DEATH

County Cedar Registration District No. 163 File No. _____
 Township El Dorado Primary Registration District No. 4095 Registered No. 29
 City Willard No. _____ St. _____ Ward _____

2. FULL NAME

(a) Residence No. _____ Ward _____
 (Usual place of abode)

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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 1956

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
69 1 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farming
 (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) Mo

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo

14.

INFORMANT Florence B Gorte
 (Address)

15.

FILED 530 25

W S Dawson
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 29 1925

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

(that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.)

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Spontaneous
Heart
no physician
82A (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED no

IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) W S Dawson

29 1925 (Address) El Dorado Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE, 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

Lincoln Mo

20. UNDERTAKER

ADDRESS

M D Gorman

LOCAL REGISTRAR'S REPORT—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..... Registration District No..... File No.....
Township..... Primary Registration District No..... Registered No.....
City..... (No. Sl. Ward)

2. FULL NAME

(a) Residence, No. Sl. Ward.
(Usual place of abode)
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 (circle 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 mins.

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)

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

that I last saw him alive on....., 19....., to....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY
(SECONDARY)

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)

M, D

*State the DISEASE CAUSING DEATH, or in deaths from VICARIOUS 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

20. UNDERTAKER

ADDRESS