

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

20539

1. PLACE OF DEATH

County *Butler*Registration District No. *311*

File No.

Township *Bay*Primary Registration District No. *2430*Registered No. *11*City *St. Louis*

No.

St. Ward

2. FULL NAME

(a) Residence. No. St. Ward.

(Usual place of abode)

Length of residence in city or town where death occurred *10* yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR

DIVORCED (write the word)

Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF

(OR) WIFE OF

Wife

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

Aug. 1, 1879

7. AGE

YEARS

95

MONTHS

11

DAYS

22

If LESS than 1

day, hrs.

or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or

particular kind of work

Housewife

(b) General nature of industry,

business, or establishment in

which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Richmond N.Y.

(STATE OR COUNTRY)

10. NAME OF FATHER

James Stephens

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Unknown

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

N.Y.

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

Frank Thomas

15.

FILED

July 23, 1925

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

July 23, 1925

17.

I HEREBY CERTIFY That I attended deceased from

July 20, 1925 to *July 20, 1925*that I last saw him alive on *July 20, 1925*, and that

death occurred on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*metastatic carcinoma**90*

(duration) yrs. mos. ds.

CONTRIBUTORY

(SECONDARY)

(duration) yrs. mos. ds.

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) *E. N. McChesney* M. D.*July 23, 1925* (Address) *Butler 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

New Friendship

DATE OF BURIAL

July 24, 1925

20. UNDERTAKER

J. R. Shockey

ADDRESS

Abany Mo

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

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.)..... St..... Ward.....

2. FULL NAME

(a) Residence, No..... St..... Ward.....
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. (If nonresident give city or town and State)
da. 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 (write the word)

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND or (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)

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY).....
(duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED.....
(duration)..... yrs. mos. ds.

IF NOT AT PLACE OF DEATH.....

*DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D.
19..... (Address)

*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.....

20. UNDERTAKER..... ADDRESS.....