LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

27335

LACE OF DEATH
County Jasper
Township
City Webb City

Registration District No. 417
Primary Registration District No. 3021
File No. 147
Registered No.
(No. ..... St. ..... Ward)

ULL NAME E. Raymond Justin
(a) Residence. No. 925 W. 2nd St. ..... Ward.
(Usual place of abode)
(If nonresident give city or town and State)
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)
le	White	Single

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

E OF BIRTH (MONTH, DAY AND YEAR) Jan 30-1906

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
19	7	17	

UPATION OF DECEASED
) Trade, profession, or
rticular kind of work With Daily Sentinel
) General nature of industry,
siness, or establishment in
ich employed (or employer)
) Name of employer

THPLACE (CITY OR TOWN) Lakes Side
TATE OR COUNTRY) Mo.
NAME OF FATHER E. R. Justin
BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Kansas
MAIDEN NAME OF MOTHER Gertrude McCafferty
BIRTHPLACE OF MOTHER (CITY OR TOWN) Jasper Co
(STATE OR COUNTRY) Mo.
ORMANT E. R. Justin
dress) Webb City
ED 9/20, 1925 R. M. Stremont
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 17 1925

17. I HEREBY CERTIFY, That I attended deceased from 9/12, 1925, to 9/17, 1925, that I last saw him alive on 9/17, 1925, and that death occurred, on the date stated above, at 4:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Intestinal Perforation & Peritonitis
(duration) ..... yrs. ..... mos. 1 ds
CONTRIBUTORY (SECONDARY) Typhoid Fever
(duration) ..... yrs. ..... mos. 8 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) W. L. Pressure, M. D
(Address) Webb City 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
Pine Cem.	Sept 20 1925
20. UNDERTAKER	ADDRESS
Steele Und. Co.	Webb City

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. .....W

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) 9/20

17. I HEREBY CERTIFY, That I attended deceased from 9/12, 19 25, to 9/17, 19 25, that I last saw h. alive on 9/17, 19 25, death occurred, on the date stated above, at 11:20 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Intestinal Perforation
of Pertonitis
.....(duration).....yrs. .....mos.

CONTRIBUTORY (SECONDARY) Typhoid Fever
.....(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) T. L. Inlehell
9/20, 19 25 (Address) Nevada, Mo.

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
20. UNDERTAKER	ADDRESS

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.

V. S. No. 2.