9165

APR 24 1926

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 Monroe — Registration District No. 579 — File No.
Township Marion — Primary Registration District No. 5776B — Registered No.
City Madison (No. ... St. ... Ward)

2. FULL NAME David Crockett Enochs
(a) Residence. No. ... St., ... Ward. ... (If nonresident give city or town and State)
(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)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4/3-1838
7. AGE: Years 86 | Months 9 | Days 25 | If LESS than 1 day, ... hrs. or ... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work retired
(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) Monroe Co, Mo.

PARENTS
10. NAME OF FATHER David Enochs
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ky
12. MAIDEN NAME OF MOTHER Nancy Davis
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ky

14. INFORMANT Robt Enochs (Address) Moberly
15. FILED 3/29, 1926. Fred A Thompson, REGISTRAR. W. D. Eenbank

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/28 1926
17. I HEREBY CERTIFY, That I attended deceased from Mch 15, 1926 to Mch 26, 1926 that I last saw him alive on Mch 26, 1926, and that death occurred, on the date stated above, at 7 p m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cardiac Insufficiency
9 B
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (SECONDARY) 90A
(duration) ... yrs. ... mos. ... ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
8 DID AN OPERATION PRECEDE DEATH? ... DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) E. Baker, M. D
3/30, 1926 (Address) Madison

*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: Sunset Hill — DATE OF BURIAL: 3/30 1926
20. UNDERTAKER: Fred A Thompson — ADDRESS: Madison

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

Revised United States Standard

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 Sta

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 COUNTY)

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 CAUSES (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

"Typhoid pneumonia"; *Lobar pneumonia; Broncho-*