LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

JUN 25 1926

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

17030

PLACE OF DEATH
County Newton — Registration District No. 612 — File No.
Township Van Buren — Primary Registration District No. 5814 — Registered No.
City (No. St. Ward)

FULL NAME Unnamed
(a) Residence. No. RFD# Sarcoxie Mo Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 0 yrs. 0 mos. 7 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 (write the word)
...le	White	Single

IF MARRIED, WIDOWED, OR DIVORCED
~~HUSBAND OF~~
(OR) ~~WIFE OF~~

DATE OF BIRTH (MONTH, DAY AND YEAR) May 10 - 1926

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
	—	—	7	

OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

BIRTHPLACE (CITY OR TOWN) Newton Co. Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Elmer A. Howell
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Jasper Co. Mo.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Elsie Hazel Duke
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Jasper Co. Mo.
(STATE OR COUNTRY)

INFORMANT Elmer Howell
(Address) Sarcoxie Mo RFD#2

FILED June 8 1926 C. P. Moody. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 17 1926

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1926, to May 17, 1926, that I last saw him alive on May 12, 1926, and that death occurred, on the date stated above, at 5 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Patent foramen ovale 15 7e
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (SECONDARY) 15 7e
(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) Leroy Simmons, M. D
May 17, 1926 (Address) Sarcoxie, 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
Sarcoxie Cem.	May 17 1926
20. UNDERTAKER	ADDRESS
Sarcoxie Und Co	Sarcoxie Mo

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.

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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. .....Ward

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. d

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) 19

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

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.....

.....

.....

.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.

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IF NOT AT PLACE OF DEATH?.....

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

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