JUL 29 1926

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

1 PLACE OF DEATH

County Polk

Township Campbell
or
Village Dunnegan
or
City ..... (NO. ..... St.; ..... Ward)

Registration District No. 706 File No. 23274

Primary Registration District No. 5935 Registered No. .....

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME James Losin LaRew

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: December (Month) 26 (Day), 1871 (Year)

7 AGE: 54 yrs. 6 mos. 8 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (City or town, State or foreign country): Knoxville, Tenn.

PARENTS

10 NAME OF FATHER: John Losin LaRew

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Tenn.

12 MAIDEN NAME OF MOTHER: Leni Gaudin

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Tenn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lula E. LaRew

(Address) Dunnegan, Mo.

15

Filed ....., 191...., ...
Registrar

2 **MEDICAL CERTIFICATE OF DEATH**

16 DATE OF DEATH: July (Month) 4 (Day), 1926 (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 4, 1926, to July 4, 1926, that I last saw him alive on July 4, 1926, and that death occurred, on the date stated above, at 11:20 P m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular disease

95 B

82 D

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Paralysis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. E. Thompson M. D.

July 10, 1926 (Address) Dunnegan, Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence Dunnegan, Mo

19 PLACE OF BURIAL OR REMOVAL: Humansville, Mo

DATE OF BURIAL: July 6, 1926

20 UNDERTAKER

ADDRESS: Humansville Mo

...IN RESERVED F... ...A RECORD

...B.—Every item of information should be carefully supp... AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be prop... classified. Exact statement of OCCUPATION is very important.

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or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

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.

WRITE PLAINLY, WITH UNFADING INK.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day) ....., 1..... (Year)

7 AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day) ....., 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from

....., 191....., to ....., 191.....,

that I last saw h.....alive on ....., 191.....,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) .....M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL ....., 191.....

20 UNDERTAKER

ADDRESS