JAN 25 1926

35371

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

~~34371~~

1 PLACE OF DEATH

County Macon

Township Walnut

or

Village Ethel

or

City ..... (NO. ..... St. ..... Ward)

Registration District No. 531 File No. 2

Primary Registration District No. 4317 Registered No. 4

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

2 FULL NAME William Jefferson Heaton

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 Nov (Month) 28 (Day) 1848 (Year)

7 AGE 78 yrs. 11 mos. 24 ds. If LESS than 1 day ..... hrs. or ..... min.?

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

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

PARENTS

10 NAME OF FATHER James Hatan

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

12 MAIDEN NAME OF MOTHER Arsind Jackson

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martha Heaton

(Address) Ethel Mo

15

Filed Dec 15, 1926 J M Troutman Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov (Month) 21 (Day) 1926 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Nov 4, 1926, to Nov 21, 1926 that I last saw him alive on Nov 21, 1926 and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

82 A

(Duration) 74 yrs. ..... mos. 17 ds.

CONTRIBUTORY (Secondary) .....

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

(Signed) J A Shocklett M. D.

Nov 28, 1926 (Address) Ethel 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 .....

19 PLACE OF BURIAL OR REMOVAL Bell Cemetery

DATE OF BURIAL Nov 24, 1926

20 UNDERTAKER H Heyning

ADDRESS Ethel Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated [illegible]. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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

1 PLACE OF DEATH

County .....

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

[If death
hospital o
give its F
of street a

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

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

17 I HEREBY CERTIFY, that I attended dec

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

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

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

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mo

CONTRIBUTORY .....
(Secondary)

..... (Duration).....yrs.....mo

(Signed) .....

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

*State the Disease Causing Death, or, in deaths from Violen
(1) Means of Injury; and (2) whether Accidental, Suicidal o

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

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

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

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BU

20 UNDERTAKER	ADDRESS