

APR 27 1927

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.

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

Do not use this space.

8900

File No. 3
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH
County Madison Registration District No. 539
Township Big Creek Primary Registration District No. 5728
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Died Unnamed
(a) Residence, No. _____ St. _____ Ward _____
(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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 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) 3-4-27

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
1

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) Madison Co Mo

PARENTS

10. NAME OF FATHER Columbus Darnell

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Madison Co Mo

12. MAIDEN NAME OF MOTHER Winnie T. Combs

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Madison Co Mo

14. INFORMANT Columbus Darnell (Address) Buckhorn Mo

15. Mar 13 27 M. Carr REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-5-1927

17. I HEREBY CERTIFY, That I attended deceased from birth to death, 1927, that I last saw him/her alive on 3-5-1927, and that death occurred, on the date stated above, at 5 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Asphyxian Respiration

16/3 162
CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

9 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS:

(Signed) Adam F. Wagner, M. D.

3-6-1927 (Address) Traverton 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Buckhorn Cemetery DATE OF BURIAL 3/6 1927

20. UNDERTAKER Thomas E. A. Morgan ADDRESS _____

100

100

4

100

20

10

100

100

100

100

100

100