

JUN 24 1927

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

Do not use this space.

14438

1. PLACE OF DEATH

County Cullery  
Township St. Charles  
City (No.....)

Registration District No. 101  
Primary Registration District No. 5154

File No.....  
Registered No. 8  
St. (.....) Ward (.....)

2. FULL NAME

Unknown man

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

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.  
About 21

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work dent / repair  
(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) found floating in river 5/2/27

15. Filed 5-2-27 W. J. Williams REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Unknown 1927

I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Cause of death unknown  
Probably Drowning  
About 2 months before (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH 182

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

WAS THERE AN AUTOPSY? Coroner viewed

WHAT TEST CONFIRMED DIAGNOSIS? the body  
(Signed) Dr. Christian, M. D.

, 19 (Address) Wilton 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 DATE OF BURIAL

County Infirmary 5-8-27

20. UNDERTAKER ADDRESS Ed Thompson Wilton mo

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.



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

*may cert.*  
ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Cadaway  
Township St. Aubert  
City .....

Registration District No. 105  
Primary Registration District No. 5154

File No. ....  
Registered No. 8  
.....St. ....Ward)

**2. FULL NAME**

Unknown man

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED un (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF absolutely

6. DATE OF BIRTH (MONTH, DAY AND YEAR) not known

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 un

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) un

10. NAME OF FATHER un

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) un

12. MAIDEN NAME OF MOTHER un

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) un

14. INFORMANT (Address) un

15. FILED un REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) un 19 27

17. I HEREBY CERTIFY That I attended deceased from ..... 19 .. to ..... 19 .. that I last saw h. .... alive on ..... 19 .., and that death occurred, on the date stated above, at .....

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

CONTRIBUTORY (SECONDARY) (duration) .... yrs. .... mos. .... da.

**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) ....., M. D.  
, 19 (Address)

\*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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

19

If item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. PLACE 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

SUPPLEMENTARY

S-14438