

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

Do not use this space.

15687

1. PLACE OF DEATH

County Livingston Registration District No. 512 File No. _____
 Township Argonne Primary Registration District No. 56 & 6 Registered No. 5
 City Utica (No. _____) St. _____ Ward _____

2. FULL NAME William Riley Woolscale

(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 Male 4. COLOR OR RACE Col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 29 1866

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>61</u>	<u>1</u>	<u>23</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Livingston Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER Jimmie Woolscale

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

12. MAIDEN NAME OF MOTHER Easter Monroe

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

PARENTS

14. INFORMANT Jas. Woolscale
 (Address) 506 Hancock, Cottleville

15. FILED May 22 1927 Anna Carpenter
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 21 1927

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1926 to May 21 1927
 that I last saw h. alive on May 21 1927 and that death occurred, on the date stated above, at 8 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Aortic insufficiency

CONTRIBUTOR (SECONDARY) None (duration) 5 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED None
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) G. W. Carpenter, M. D.

5/23 1927 (Address) G. W. Carpenter

*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 Chellcoth
Wich. Col. Cemetery DATE OF BURIAL 5-24 1927

20. UNDERTAKER F. B. Norman Chellcoth
 ADDRESS _____

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Post mail Bureau
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London 52.10.1917

London 52.10.1917

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Sturgeon Registration District No. 512 File No. _____
 Township Greene Primary Registration District No. 5686 Registered No. 5
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Ann Riley Wassdale
 (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

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE B 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (write the word)

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 21 1927

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

17. I HEREBY CERTIFY That I attended deceased from _____, 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:

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 _____

CONTRIBUTORY _____ (duration) _____ yrs. _____ mos. _____ ds.
 SECONDARY _____ (duration) _____ yrs. _____ mos. _____ ds.

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

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.

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) _____

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

15. FILED May 22 1927 Anna Carpenter REGISTRAR

20. UNDERTAKER _____ ADDRESS _____

Exact statement of OCCUPATION is very important. perily-classified. Exact statement of OCCUPATION is very important. FILE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW CAUSE OF DEATH (ALL NOT RECEIVED)

SUPPLEMENTARY

May 24 1927

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