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

Do not use this space.

15932

JUN 29 1927

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.

1. PLACE OF DEATH
County: Pettis.
Township: Blackwater No 2
City: ..... (No. ....., ... St. ..... Ward)
Registration District No. 112
Primary Registration District No. 6886
File No. .....
Registered No. 6

2. FULL NAME: William Oscar Means

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W=
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov 28 1844

7. AGE

Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
82	5	20	

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

9. BIRTHPLACE (CITY OR TOWN) ~~James Means~~
(STATE OR COUNTRY) Ky.

PARENTS

10. NAME OF FATHER: James Means
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ky
12. MAIDEN NAME OF MOTHER: Sarah Anderson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ky

14. INFORMANT: Cirelius Means
(Address) La Monte Mo

15. FILED May 19 27 Florence S Tyler
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): May 17 1927

17. I HEREBY CERTIFY, That I attended deceased from May 1 1920, to May 17 1927, that I last saw h. ~~alive~~ alive on May 17 1927, and that death occurred, on the date stated above, at 12:15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senility

11 yr (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 64

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No DATE OF. .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) W. E. Walker, M. D
, 19 (Address) La Monte 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: County Line
DATE OF BURIAL: May 19 1927

20. UNDERTAKER: B F Parrish
ADDRESS: La Monte Mo

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registration District No. .....

Primary Registration District No. .....

City ..... No. ..... Ward .....

2. FULL NAME .....

(a) Residence No. ..... St. ..... Ward .....

(Usual place of abode)

(If inside the limits of the city or town where death occurred) yrs. mos. da. How long in U.S., if of foreign birth? yrs.

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL C
3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)	

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

7. DATE O