

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

Do not use this space.

**1. PLACE OF DEATH**

County.....  
Township.....  
City.....

Registration District No. **791**  
Primary Registration District No. **1003**  
(No. *Isolation*)

File No. **16959**  
Registered No. **4920**  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. **2919 Park** St., **18** Ward.  
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. **19** 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 **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Single**  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Single**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Sept-11-1925**  
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
**1 8 14**

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

9. BIRTHPLACE (CITY OR TOWN) **Ky.**  
(STATE OR COUNTRY)

10. NAME OF FATHER **Dean Terrill**  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Tenn.**  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER **Ollie Johns**  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Tenn.**  
(STATE OR COUNTRY)

14. INFORMANT **M. O'Brien**  
(Address) **5600 Arsenal**

15. FILED **MAY 25 1927** **max b Starvo**  
REGISTRAR

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **May 25 1927**  
17. I HEREBY CERTIFY That I attended deceased from **May 24**, 19**27**, to **May 25**, 19**27** that I last saw him alive on **May 25**, 19**27**, and that death occurred, on the date stated above, at **2:45 a.m.**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
**Measles**  
**107A** (duration) — yrs. — mos. **5** ds.  
CONTRIBUTORY (SECONDARY) **Bronchopneumonia**  
**Secondary** (duration) — yrs. — mos. **2** ds.

18. WHERE WAS DISEASE CONTRACTED **2919 Park**  
IF NOT AT PLACE OF DEATH?

19. DID AN OPERATION PRECEDE DEATH? **No.** DATE OF.....  
WAS THERE AN AUTOPSY? **No.**  
WHAT TEST CONFIRMED DIAGNOSIS? **Clinical**  
(Signed) **Samuel Garrison, M.D.**  
, 19 (Address) **Isolation Hospital**

\*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 **Fulton Ky** DATE OF BURIAL **May 25 1927**

20. UNDERTAKER **Thos J Finner** ADDRESS **1527 8th**

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.

WRITE IN INK WITH UNFADING INK—THIS IS A PERMANENT RECORD

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S/S