8 1927

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

Do not use this space.

1. PLACE OF DEATH.
County Newton — Registration District No. 612 — File No. 19033
Township Van Buren — Primary Registration District No. 5814 — Registered No.
City Reeds — (No. ..... St. ..... Ward)

2. FULL NAME Wilford H Urquhart
(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 4 yrs. ✓ mos. ✓ ds. How long in U.S., if of foreign birth? 34 yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married —

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 25 - 1874

7. AGE: 53 YEARS | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Canada —

PARENTS
10. NAME OF FATHER Don't Know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Scotland
12. MAIDEN NAME OF MOTHER Archer — ✓
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Canada —

14. INFORMANT Sadie Urquhart
(Address) Wentworth Mo

15. FILED July 8 1927 C. P. Moody REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 10 1927

17. I HEREBY CERTIFY, That I attended deceased from June 9, 1927, to June 10, 1927, that I last saw him alive on June 10, 1927, and that death occurred, on the date stated above, at 12:15 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Causes of Oesophagus
46A
44A
(duration) ..... yrs. 6 mos. ..... ds.

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 .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) C W Bergh, M. D
June 25 1927 (Address) Sarcoxie 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: Sarcoxie Cem — DATE OF BURIAL: 6/26 1927

20. UNDERTAKER: Sarcoxie Und. Co. — ADDRESS: Sarcoxie, 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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Newton Registration District No. 612 File No. .....

Township Van Buren Primary Registration District No. 58 14 Registered No. .....

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Wilford H. Urquhart

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

PERSONAL AND STATISTICAL PARTICULARS

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

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.

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)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER Henrietta ~~Archer~~ X Archer X

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

14. INFORMANT .....
(Address)

15. X FILED July 8 1927 [illegible] Moody X
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 10 1927

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 ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

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

CONTRIBUTORY (SECONDARY) .....

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

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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

[illegible] of information should be [illegible] should be stated EXACTLY. PHYSICIANS should state [illegible] Exact statement of OCCUPATION is very important.

[illegible] RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-19033