AUG 16 1927

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

Do not use this space.
20817

1. PLACE OF DEATH
County Callaway
Township
City Fulton No. St. Ward
Registration District No. 104
Primary Registration District No. 3008
File No.
Registered No. 124

2. FULL NAME James L. Herring
(a) Residence. No. Calloway Co Mo 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. 4 mos. 25 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) No information

7. AGE: Years 70 | Months No information | Days | If LESS than 1 day, hrs. or min.

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)
(STATE OR COUNTRY) No information

PARENTS
10. NAME OF FATHER No information
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) No information
12. MAIDEN NAME OF MOTHER No information
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) No information

14. INFORMANT Hospital Records
(Address) Fulton Mo

15. Filed July 5 1927 L. N. Crews
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 4 1927

17. I HEREBY CERTIFY, That I attended deceased from July 9 1927 to July 4 1927 that I last saw him alive on July 4 1927, and that death occurred, on the date stated above, at 1540 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
37 days
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Senile Bronchitis
(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? Clinical Symps
(Signed) H. Frozer, M. D
7-4-, 1927 (Address) Fulton 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 Hillcrest Cemetery
DATE OF BURIAL 7/5 1927

20. UNDERTAKER Herndon Taylor
ADDRESS Fulton 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.