SEP 26 1927

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

Do not use this space.

23527

File No.

Registered No. 116

**1. PLACE OF DEATH**

County Audrain — Registration District No. 26

Township Salisbury — Primary Registration District No. 5034

City Mexico Mo. R.F.D. No. ..... St. ..... Ward)

**2. FULL NAME** Samuel Foster White

(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. ..... 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) |
|---|---|---|
| male | white | widower |

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 18 - 1848

| 7. AGE | Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|---|
| 79 | | 6 | 11 | |

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Will Co.
(STATE OR COUNTRY) Ill.

PARENTS

10. NAME OF FATHER Charles White

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

12. MAIDEN NAME OF MOTHER Jane Sloan

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

14. INFORMANT Mrs. J. J. Bezner
(Address) Mexico Mo. R.F.D.

15. FILED Sept 1st 1927. Ira S. Milligan REGISTRAR

## 2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 29 1927

17. I HEREBY CERTIFY, That I attended deceased from July 15 1927, to Aug. 29 1927 that I last saw h. alive on Aug. 29 1927, and that death occurred, on the date stated above, at 6.40 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hemiplegia

Coma

Stroke (duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (SECONDARY) Hemorrhage of Blood Vessel to Brain (duration) ..... yrs. ..... mos. 14 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) R. W. Van Dyke M. D.

, 1927 (Address) Mexico 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 | DATE OF BURIAL |
|---|---|
| Clarinda Iowa | Sept 2nd 1927 |
| **20. UNDERTAKER** | **ADDRESS** |
| McPherson Bros. | Mexico Mo. |

N. B.—By state ... important. CAUSE O... ...ssified. ...

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

**ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.**

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 coded. Incorrect statement of OCCUPATION is very important. REGISTRARS AND UNDERTAKERS are required by LAW to report to the State Board of Health any violation of the law they may find.

**1. PLACE OF DEATH**

County: Ray County — Registration District No.: 24 — File No.:

Township: Salt River — Primary Registration District No.: 5034 — Registered No.: 116

City: (No. St. Ward)

**2. FULL NAME** Samuel Porter White

(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 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)

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

14. INFORMANT
(Address)

15. FILED Sept 1st, 1927. Ira S. Milligan REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 29 1927

17. I HEREBY CERTIFY, That I attended deceased from , 19 to , 19 that I last saw b alive on , 19 , and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hemorrhagic gi
Cause unknown but
seemed to be no violence that caused
the hemorrhage. Died dead in bed.

CONTRIBUTORY (SECONDARY) Nervous Exhaustion
Nervous in Brain (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

5-23527