

**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. **3850^e De Trinity**)

File No. **28340**
Registered No. **7850**
St. _____ Ward _____

2. FULL NAME

Oliver Perry La Mar

(a) Residence. No. **3850^e De Trinity** St. **17** 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 *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 *Angie O. La Mar*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 8-1854*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
73 1 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Salesman*
(b) General nature of industry, business, or establishment in which employed (or employer) *Scrygs-Underwood*
(c) Name of employer *V Barney D. S.*

9. BIRTHPLACE (CITY OR TOWN), *Henryville*
(STATE OR COUNTRY) *Indiana*

10. NAME OF FATHER *Allen La Mar*

11. BIRTHPLACE OF FATHER (CITY OR TOWN),
(STATE OR COUNTRY) *Not Known*

12. MAIDEN NAME OF MOTHER *Not Known*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN),
(STATE OR COUNTRY) *Not Known*

14. INFORMANT *Robert C. La Mar*
(Address) *5560 Rushing*

15. FILED **SEP-3 1927** *Max G Starckoff*
19 _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 2 19 27*

17. I HEREBY CERTIFY, That I attended deceased from *Aug 15 1927*, to *Sept 2 19 27* that I last saw him alive on *Sept 1 19 27* and that death occurred, on the date stated above, at *8 A.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
3 1/2 (duration) *2 2 2* yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *Pulmonary Infarct*
(duration) *17* yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? *Not Known*
IF NOT AT PLACE OF DEATH? *Not Known*

DID AN OPERATION PRECEDE DEATH? *No* DATE OF _____

WAS THERE AN AUTOPSY? *No*

WHAT TESTS CONFIRMED DIAGNOSIS? *Staining*

(Signed) *J. H. Beecher* M. D.
, 19 (Address) *3202 Lafayette Ave*

*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 *Carmi Ill* DATE OF BURIAL *Sept 5 19 27*

20. UNDERTAKER *Hauch & Schmidt* ADDRESS *8 Grand*

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.

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