JAN 5 1928

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

Do not use this space.

33884

1. PLACE OF DEATH
County Jasper
Township
City Sarcoxie (No. St. Ward)
Registration District No. 416
Primary Registration District No. 4248
File No.
Registered No. 15

2. FULL NAME James Taylor Bickford
(a) Residence (Usual place of abode) No. St., Ward. (If nonresident give city or town and State)
Length of residence in city or town where death occurred 30 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 Jennie Bickford

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 29 1847

7. AGE: Years 80 | Months 6 | Days 7 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Stone Mason.
(b) General nature of industry, business, or establishment in which employed (or employer): " "
(c) Name of employer: Homer Russell

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

PARENTS
10. NAME OF FATHER: Dont Know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Dont Know
12. MAIDEN NAME OF MOTHER: Dont Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Dont Know

14. INFORMANT: Mrs Bickford
(Address) Sarcoxie Mo

15. FILED Nov 6 1927 Leroy Simmons REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov - 5th - 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan - 1, 1927, to Nov 5, 1927, that I last saw him alive on Nov 4, 1927, and that death occurred, on the date stated above, at 4:00 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Uraemia - chronic 131
nephritis 132B
129A 162
(duration) yrs. mos. 10 ds.

CONTRIBUTORY (SECONDARY) Senility
(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) J W Boyd, M. D
, 19 (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: Nov 6 27

20. UNDERTAKER: Sarcoxie Furn & Hdw 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD