

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

Do not use this space.

36647

1. PLACE OF DEATH

County Henry
Township Sheldon
City Sheldon

Registration District No. 14

Primary Registration District No. 4211

File No. _____

Registered No. 40

St. _____ Ward _____

2. FULL NAME

(a) Residence No. _____ St. _____

(Usual place of abode)

Ward. _____

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. _____

mos. _____

da. _____

How long in U.S., if of foreign birth?

yrs. _____

mos. _____

da. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4

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 W. T. Larson

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

7. AGE

YEARS 40

MONTHS 11

DAYS 22

IF LESS than 1
day, _____ hrs.
or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work housewife

(b) General nature of industry,
business, or establishment in
which employed (or employer) 184

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Ind.

10. NAME OF FATHER Geo. Bennett

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Pa.

12. MAIDEN NAME OF MOTHER Sarah Bennett

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Ind.

14.

INFORMANT W. T. Larson

(Address) Sheldon

15.

FILED Dec 11

19 27

W. T. Bennett

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 7 1927

17.

I HEREBY CERTIFY, That Deceased deceased from _____

that I last saw him last Dec 7th 1927, and that
death occurred, on the date stated above, at 4:15 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Result of a wound
in the left head from
a revolver. (duration) 1 yrs. 1 mos. 1 da.

CONTRIBUTORY

(SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. Ind.

19. DID AN OPERATION PRECEDE DEATH? No.

DATE OF _____

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? No.

(Signed) H. T. Jennings

, 19 _____

(Address) Clinton Mo.

M. D.

*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

First Church Cemetery

Dec 11 1927

20. UNDERTAKER

W. E. Huston

ADDRESS

Sheldon

1. The purpose of this report is to present a summary of the work done by the Committee on the Control of Mosquitoes during the year 1944.

2. The Committee was organized in 1943 and has since that time been engaged in a study of the problem of mosquito control.

3. The Committee has held several meetings and has received many suggestions from the public and from the scientific community.

4. The Committee has also conducted a number of experiments and has collected a large amount of data.

5. The results of these experiments and the data collected have been summarized in this report.

6. It is hoped that this report will be of some value to the public and to the scientific community.

7. The Committee is grateful to the many individuals and organizations who have assisted it in its work.

8. The Committee is also grateful to the many individuals and organizations who have contributed to the control of mosquitoes.

9. The Committee is also grateful to the many individuals and organizations who have helped to make the control of mosquitoes a more effective and efficient process.

10. The Committee is also grateful to the many individuals and organizations who have helped to make the control of mosquitoes a more pleasant and enjoyable process.

11. The Committee is also grateful to the many individuals and organizations who have helped to make the control of mosquitoes a more successful process.

12. The Committee is also grateful to the many individuals and organizations who have helped to make the control of mosquitoes a more complete process.

13. The Committee is also grateful to the many individuals and organizations who have helped to make the control of mosquitoes a more thorough process.

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**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 Henry
Township _____
City Windsor

Registration District No. 14
Primary Registration District No. 4211

File No. _____
Registered No. 40
St. _____ Ward _____

2. FULL NAME

Elsie E Larison

(a) Residence. No. _____ St. _____ Ward _____
(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) 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.
40 11 22

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) _____

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 Aug 27/13 Jemings
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 7 1927

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

Result of a wound on the side of the head from a revolver, accidental

CONTRIBUTORY (SECONDARY)

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

20. UNDERTAKER

ADDRESS

SUPPLEMENTARY

AS PRESENTED BY LAW

IF THEY ARE CO-

WIFICATES

HALL NO.

REGISTRAR

N. B. CAUSE OF DEATH

5-36697