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

Do not use this space.

37821

1. PLACE OF DEATH

County Pike Registration District No. 684

Township Center Primary Registration District No. 4404

City Bowlinggreen (No. ..... St. ..... Ward)

File No. ..... Registered No. 46

2. FULL NAME Warren Cuthbertson

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

Length of residence in city or town where death occurred 10 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)
M	W	Married

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Nellie May Martin Cuthbertson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2/16-1865

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	9	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer) Bath
(c) Name of employer Jim Hendrix

9. BIRTHPLACE (CITY OR TOWN) Near Louisiana
(STATE OR COUNTRY) Mo Pike Co

PARENTS

10. NAME OF FATHER John Cuthbertson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Dont Mo
(STATE OR COUNTRY) Dont Mo / Ky
12. MAIDEN NAME OF MOTHER Elizabeth Spencer
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Louisiana
(STATE OR COUNTRY) Pike Co Mo

14. INFORMANT Nellie May Cuthbertson wife
(Address) Bowlingreen Mo

15. FILED 1/10, 1928. W. E. Summerhays
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 10 1927

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Natural Causes Cancer and around the Heart also Pneumonia
11 d (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 105
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Dont Mo

O DID AN OPERATION PRECEDE DEATH? No. DATE OF None

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? None Made

(Signed) C. W. Davis Coroner
, 19 (Address) Bowlingreen 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
Bowling Green Mo	Dec 12 1927
20. UNDERTAKER	ADDRESS
Grace Bankhead	Bowling Green Mo

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Pike Registration District No. 684 File No.
Township Primary Registration District No. 4408 Registered No. 46
City Bowling Green No. St. Ward)

2. FULL NAME Warren Author

(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)
M	W	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.

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
(STATE OR COUNTRY)

All Coroner Knew About the Case

14. INFORMANT
(Address)

15. FILED May 10 1928 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 10 1927

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Natural Causes

Asthma

.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY (SECONDARY)

.....(duration).....yrs. .....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH?..... DATE OF
IS 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

DO NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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