

21 1928

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

Do not use this space.

5486

1. PLACE OF DEATH

County Lafayette Registration District No. 466
Township Clay Primary Registration District No. 3622C
City..... St. Ward)

File No.....
Registered No. 1

2. FULL NAME John White

(a) Residence. No..... St..... Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 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 Abner M. White

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 26 - 1877

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
50 | 3 | 6

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(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) Odessa Lafayette Co, Ky

10. NAME OF FATHER John White

11. BIRTHPLACE OF FATHER (CITY OR TOWN, STATE OR COUNTRY) Kentucky

12. MAIDEN NAME OF MOTHER Adaline Abbott

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

14. INFORMANT Mollie White
(Address) Odessa, Missouri

15. FILED Feb 1 1928 F. H. Mann REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 1st 1928

17. I HEREBY CERTIFY, That I attended deceased from Feb 1st 1928, to Feb 1st 1928, that I last saw him alive on Feb 1st 1928, and that death occurred, on the date stated above, at 6:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Voluntary Heart Disease
92A ✓

11K6 (duration) yrs. mos. ds. 1 hr
CONTRIBUTORY (SECONDARY) Indigestion (duration) yrs. mos. ds. 6 hrs

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

8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

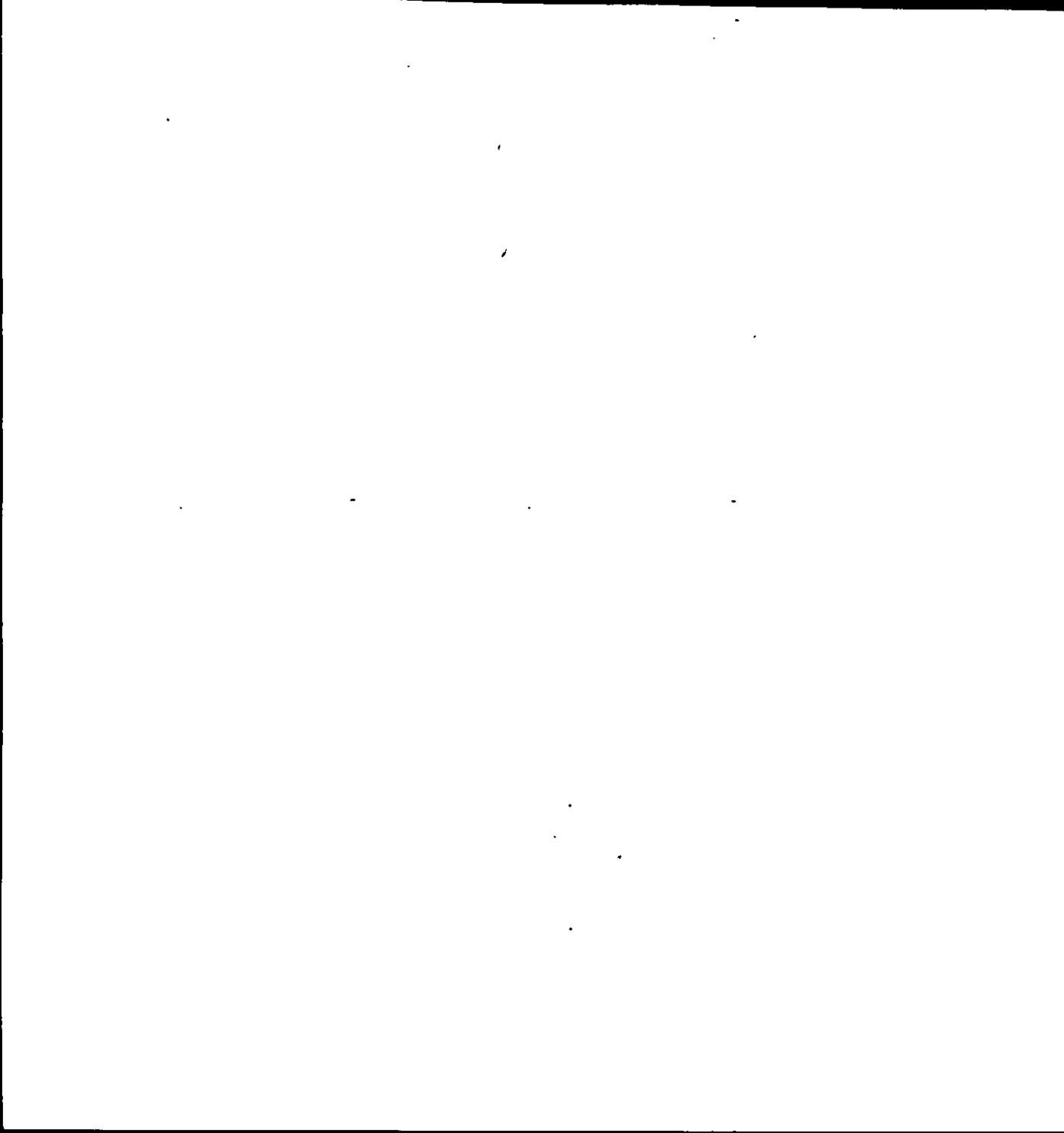
WHAT TEST CONFIRMED DIAGNOSIS
(Signed) F. H. Mann M. D.
(Address) Wellington, Mo

*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 Wt Labor DATE OF BURIAL 2-2 1928

20. UNDERTAKER Bhewood Sons ADDRESS Odessa

PARENTS



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

ALL INFORMATION REQUESTED
HEREIN MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Lafayette Registration District No. 466 File No. _____
 Township Clay Primary Registration District No. 6a 22c Registered No. _____
 City _____ (No. _____, _____ St. _____ Ward)

2. FULL NAME

John 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M. (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)

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 _____ 19. J. M. Mason REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-1-1938

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:
VALVULAR HEART DISEASE

90a
 (duration) _____ yrs. _____ mos. _____ da.
 CONTRIBUTORY (SECONDARY) Indigestion, Over eating
 (duration) _____ yrs. _____ mos. _____ da.

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

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

①
P.