

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

Do not use this space.

MAR 19 1928

**1. PLACE OF DEATH**

County.....*Linn*.....  
Township.....*Union*.....  
City.....(No.....).....St. ....Ward)

Registration District No.....*490 363*.....  
Primary Registration District No.....

File No.....*5538*.....  
Registered No.....

**2. FULL NAME**

*Mordecai Miller Wammack*

(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.....*m.*.....4. COLOR OR RACE.....*White*.....5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word).....*Infant*.....

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.  
.....*9*.....

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work.....*Infant*.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN).....*Silex Mo.*.....  
(STATE OR COUNTRY)

10. NAME OF FATHER.....*Bertan Wammack*.....

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....*Linn Co. Mo*.....  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER.....*Kathyrine Miller*.....

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....*St. Louis Mo.*.....  
(STATE OR COUNTRY)

14. INFORMANT.....*Bertan Wammack*.....  
(Address).....*Silex Mo.*.....

15. FILED.....19.....*✓*.....REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR).....*Feb 5 1928*.....

17. I HEREBY CERTIFY, That I attended deceased from.....*Jan 29 1928*.....to.....*Feb 5 1928*.....  
that I last saw him alive on.....*Feb 5 1928*.....and that death occurred, on the date stated above, at.....*10 A m.*.....

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Broncho-pneumonia*  
*107H*  
*106H*  
.....(duration).....yrs. ....mos. ....*5*.....ds.

CONTRIBUTORY.....  
(SECONDARY).....  
.....(duration).....yrs. ....mos. ....*1*.....ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

9 DID AN OPERATION PRECEDE DEATH.....DATE OF.....

WAS THERE AN AUTOPSY?.....*no*.....

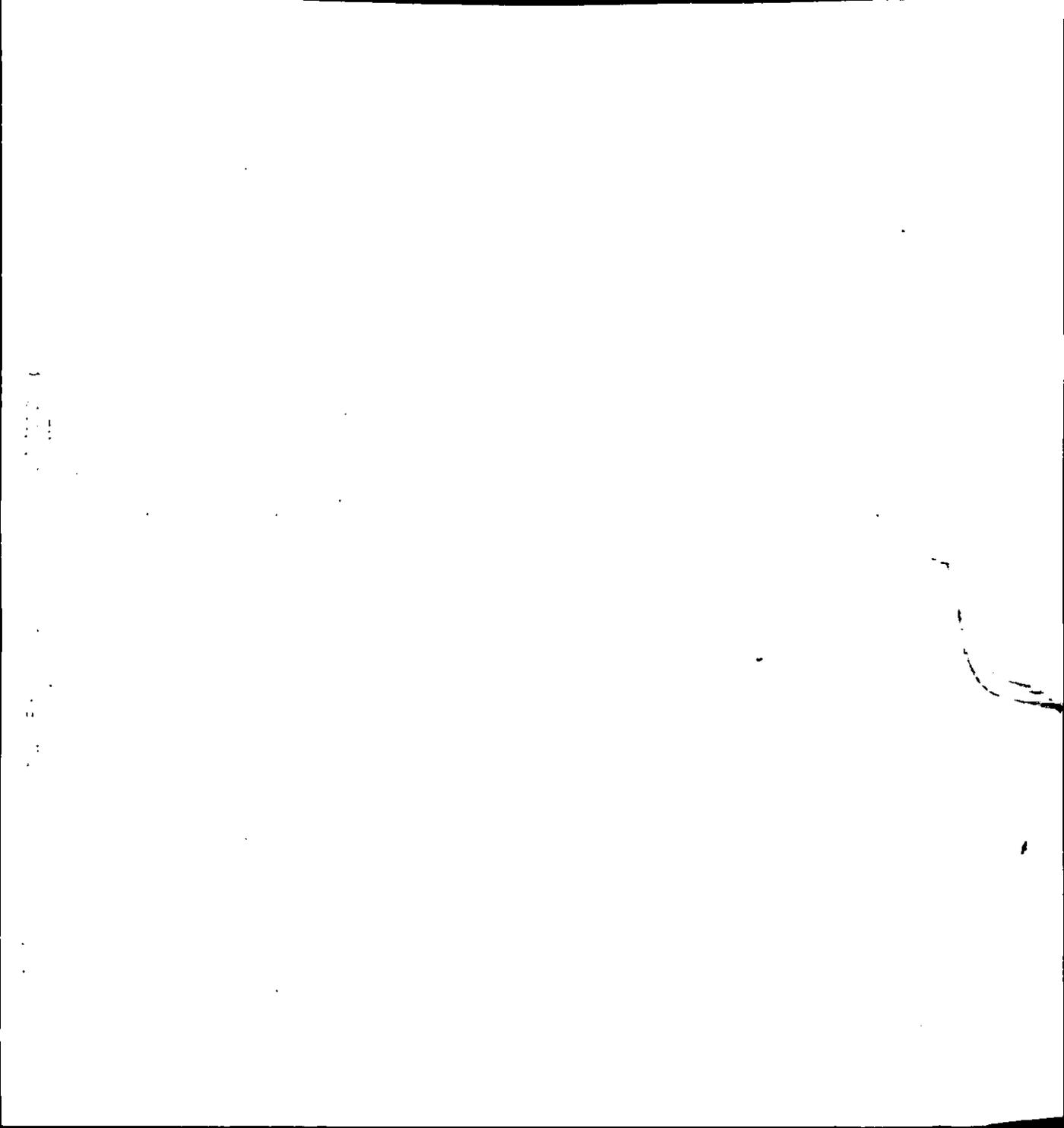
WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed).....*P. M. Turner M. D.*.....  
, 19 (Address).....*Silex 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.....*millwood cemetery*.....DATE OF BURIAL.....*Feb 6 1928*.....

20. UNDERTAKER.....*Wammack & Scheel*.....ADDRESS.....*Silex 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 Lincoln Registration District No. 490 File No. \_\_\_\_\_  
 Township Union Primary Registration District No. 5657 Registered No. \_\_\_\_\_  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Mordecai Miller Womack

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan-28-1925

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
9

**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 3-8-1928 W.H. Damon REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 5 19 28

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 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:

Primary  
Protective Pneumonia  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 CONTRIBUTORY Common Cold + Bronchitis  
 (SECONDARY) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED 1000

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

19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

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

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