

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

Do not use this space.

11981

1. PLACE OF DEATH

County Wash Registration District No. 869
 Township Piney Primary Registration District No. 6137
 City (No. _____) _____ St. _____ Ward _____

File No. _____
 Registered No. 6

2. FULL NAME Jess Samuel

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W.</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Beatrice Samuels</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>9-25-1892</u>		
7. AGE	YEARS <u>65</u>	MONTHS <u>5</u>
	DAY <u>8</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____		
9. BIRTHPLACE (CITY OR TOWN) <u>W.Va</u> (STATE OR COUNTRY)		
PARENTS	10. NAME OF FATHER <u>Jesse Samuels</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Ohio</u> (STATE OR COUNTRY)	
	12. MAIDEN NAME OF MOTHER <u>Whitelia Spencer</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>W.Va</u> (STATE OR COUNTRY)	
14. INFORMANT <u>D. S. Sears</u> (Address) <u>Waynes, Mo.</u>		
15. FILED <u>3-7-28</u> <u>J. M. Mansueti</u> REGISTRAR		

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-7-1928

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 _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
supposed heart trouble
did not receive medical aid
could be secured,
95A (duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY) 2.05W (duration) _____ yrs. _____ mos. _____ da.

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

19. 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 <u>Clare, Mo.</u>	DATE OF BURIAL <u>3-9-1928</u>
20. UNDERTAKER <u>H. V. Elliott</u>	ADDRESS <u>Houston</u>

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.

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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 Fey Registration District No. 863 File No. _____
 Township Piney Primary Registration District No. 6137 Registered No. _____
 City _____ St. _____ Ward _____

2. FULL NAME Geo Long

(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 M.
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-29-1862

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 _____ (duration) _____ yrs. _____ mos. _____ ds.
 (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 3-8-28 19. 28

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-7 19 28

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (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) Jos. Wamuck M. D.
 , 19____ (Address) Health Officer

*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 _____

INFORMATION SHOULD BE CAREFULLY SUPPLIED. PLEASE BE EXACTLY. PLEASE STATEMENT OF OCCUPATION IS IMPORTANT.
 YOU RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PERMITTED BY LAW.
 REGISTRATION CAUSE

SUPPLEMENTARY

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