

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.

16580

1. PLACE OF DEATH
 County Bole Registration District No. 213 File No. _____
 Township _____ Primary Registration District No. 3014 Registered No. 129
 City Jefferson (No. _____) St. _____ Ward _____

2. FULL NAME Lyle G. Gathright
 (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 male 4. COLOR OR RACE negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-2-28

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
		<u>3</u>	<u>20</u>	

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) Jefferson city mo
 (STATE OR COUNTRY)

10. NAME OF FATHER Lyle Gathright

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Jefferson city mo
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mable Young

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Jefferson city mo
 (STATE OR COUNTRY)

14. INFORMANT Mrs Mable Gathright
 (Address) J.C. mo

15. FILED 6-1-28 S. W. Bedford
 REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-22-1928

17. I HEREBY CERTIFY That I attended deceased from 5-20-1928, to 5-22-1928 that I last saw him alive on 5-20-1928, and that death occurred, on the date stated above, at 7:09 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
12.5B Hepatic congestion
15
 (duration) _____ yrs. _____ mos. 3 ds.

CONTRIBUTORY (SECONDARY) General debility
 (duration) _____ yrs. _____ mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: I don't know

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS: Clinical
 (Signed) R. B. Richardson, M.D.
 , 19 (Address) Jefferson City, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDE, or HOMICIDE.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL New city cemetery DATE OF BURIAL 5-23-1928

20. UNDERTAKER L. D. Hardison ADDRESS J.C. mo

RECEIVED
MAY 10 1964

SE OF DEATH IN PAIR FORM, so that it may be properly filed. In
this case, please refer to the following information.

**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 Cole Registration District No. 213 File No. _____
 Township _____ Primary Registration District No. 3014 Registered No. 129
 City Jefferson (No. _____) St. _____ Ward _____

2. FULL NAME Lyle Jr Gathright
 (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
 (of 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 _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 22 1928
 17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____, 19____, and that death occurred, on the date stated above, at _____ m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hepatic congestion
exposure
 (duration) yrs. mos. ds. _____
 CONTRIBUTORY General debility
 (SECONDARY) (duration) yrs. mos. ds. _____

18. WHERE WAS DISEASE CONTACTED _____
 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.

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

PARENTS

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 1-1-28 S. Bedford REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

N. B. - CAUSE should be stated EXACTLY. PH. Y. should state important. Exact statement of OCCUPATION. REGISTERS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

