

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

Do not use this space.

16740

1. PLACE OF DEATH

County Central
Towship Lawrence
City (No.)

Registration District No. 309
Primary Registration District No. 5439

File No.
Registered No. 29
St. Ward)

2. FULL NAME

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

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 21 1928

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

17. I HEREBY CERTIFY That I attended deceased from May 12 1928 to May 21 1928 that I last saw him alive on May 21 1928, and that death occurred, on the date stated above, at 5:50 p.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 04-11-1841

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
86 7 10

1867 Shock. Falling Injury 1945
1187 (duration) yrs. mos. ds.

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

CONTRIBUTORY (SECONDARY) Chronic Gastritis
(duration) 5 yrs. mos. ds.

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

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

10. NAME OF FATHER John Manger

0 DID AN OPERATION PRECEDE DEATH. DATE OF

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

19. WAS THERE AN AUTOPSY? no

12. MAIDEN NAME OF MOTHER William

WHAT TEST CONFIRMED DIAGNOSIS. none

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) 11
(STATE OR COUNTRY)

(Signed) Louis H. Lay, M. D.
May 23, 1928 (Address) Denver Colo.

14. INFORMANT H. T. Darby
(Address) 5 ever. mo.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Louis Star DATE OF BURIAL 5/22 1928

15. FILED May 29 1928 W. F. Martin REGISTRAR

20. UNDERTAKER Frank Proa ADDRESS Denver

Exact statement of OCCUPATION is very important.

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Wentworth
Township Howard
City (No.) St. Ward

Registration District No. 309
Primary Registration District No. 3-4-34

File No.
Registered No. 24
St. Ward

2. FULL NAME

Sarah Jane Darby

(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

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

wid

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

July 14 25 W. F. Martin

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 21 1928

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

Shock, following injury, fell from truck shed and broke ribs and arm
CONTRIBUTORY chronic gastritis
(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) 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

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

SUPPLEMENTARY

185

