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

16746

PLACE OF DEATH

County Gentry

Township Cooper

or

Village Stanberry Mo

or

City _____ (NO. _____ St.; _____ Ward)

Registration District No. 314 File No. _____

Primary Registration District No. 4190 Registered No. 13

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Thomas McWhorter

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: W

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Married husbank

DATE OF BIRTH: Mary McWhorter January (Month) 13 (Day) 1843 (Year)

AGE: 85 yrs. 4 mos. 1 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): _____

BIRTHPLACE (City or town, State or foreign country): Ohio (Athens Co.)

PARENTS

NAME OF FATHER: John McWhorter

BIRTHPLACE OF FATHER (City or town, State or foreign country): Ohio

MAIDEN NAME OF MOTHER: Mace

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. O. McWhorter

(ADDRESS) Stanberry Mo

Filed 5/22 1928. C S Berndt REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: May (Month) 14 (Day) 1928 (Year)

I HEREBY CERTIFY, that I attended deceased from May 13, 1928, to May 14, 1928, that I last saw him alive on May 13, 1928, and that death occurred, on the date stated above, at 1:20 a.m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease 92 A

90A

(Duration) ___ yrs. ___ mos. ___ ds.

8 Contributory (SECONDARY) _____

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Jas. A. Crockett M. D.

May 14, 1928 (Address) Stanberry Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: Ravenwood Mo

DATE OF BURIAL: 5/16 1928

UNDERTAKER: Laton & Phillips

ADDRESS: Stanberry Mo.

PLACE OF DEATH

MISSOURI STATE BOARD
BUREAU OF VITAL STA
CERTIFICATE OF DEA

County _____

Township _____ Registration District No. _____ File No. _____
or
Village _____ Primary Registration District No. _____ Registered No. _____
or
City _____ (NO. _____ _____ St.: _____ Ward)

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____ (Month) _____ (Day), 1 _____ (Year)

AGE _____ yrs. _____ mos. _____ ds.

If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191__, _____
REGISTRAR

MEDICAL CERTIFICATE OF DE

DATE OF DEATH

_____ (Month)

I HEREBY CERTIFY, that I atte
_____, 191__, to _____
that I last saw h _____ alive on _____
and that death occurred, on the date state
The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____

Contributory _____
(SECONDARY)
_____ (Duration) _____ yrs. _____

(Signed) _____

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths f
(1) Means of Injury: and (2) whether Accidental, Suicidal,

LENGTH OF RESIDENCE (FOR HOSPITALS INSTIT
RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ y

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DA
UNDERTAKER	AD