

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

Do not use this space.

17776

538

1. PLACE OF DEATH

County Madison
Township _____
City Fredericktown, Mo.

Registration District No. _____
Primary Registration District No. 5728
St. _____ Ward) _____

File No. _____
Registered No. _____

2. FULL NAME

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

White

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

Child (Twin)

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

Child

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

7. AGE

YEARS MONTHS DAYS

If LESS than 1 day, 3 hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

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

Fredericktown, Mo.

10. NAME OF FATHER

Ben Parsons

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

Madison, Mo.

12. MAIDEN NAME OF MOTHER

Edna Wilder

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

Madison, Mo.

14. INFORMANT (Address)

Ben Parsons
Fredericktown, Mo.

15. DATE

May 31, 1928
C. U. Davis
REGISTRAR

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

5/5 1928

17. I HEREBY CERTIFY, That I attended deceased from _____, 1928, to _____, 1928, that I last saw him alive on _____, 1928, and that death occurred, on the date stated above, at _____, 1928, and that

THE CAUSE OF DEATH WAS AS FOLLOWS:

Severe mouth lesion

CONTRIBUTORY (SECONDARY)

159
1610
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

18 DID AN OPERATION PRECEDE DEATH. DATE OF

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.

(Signed) M. B. Barber, M. D.

State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Family Cemetery
5/5 1928

20. UNDERTAKER

ADDRESS

none
h

K. E.—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.

JUL

