

OCT 26

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

20255-A

1. PLACE OF DEATH

County Dade
 Township North
 City Arcola Mo. (No.)

Registration District No. 240
 Primary Registration District No. 6332

File No.
 Registered No.
 St. Ward

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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 18 18 57

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
77 2 — —

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House keeping
 (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) Illinois

PARENTS

10. NAME OF FATHER Wm. Brown

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

12. MAIDEN NAME OF MOTHER Barriett

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

14.

INFORMANT Ors Brown
 (Address) Arcola Mo.

15.

FILED 19.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 18 1929

17. I HEREBY CERTIFY, That I attended deceased from June 18 1929 to June 18 1929, that I last saw him alive on June 18 1929, and that death occurred, on the date stated above, at 2:30 PM.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

13c Chronic Dysentery
16c (duration) yrs. 1 mos. da.
 CONTRIBUTOR (SECONDARY) 16c (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

8 DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Dr. A. H. Higgins, M. D.
 , 19 (Address) Arcola Mo.

*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

Arcola

Aug. 18 1929

20. UNDERTAKER

ADDRESS

J. W. Ward

Greenville Mo.

N. B. — 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.

State

121

Person

being

given

**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 Dade
Township North
City _____ (No. _____)

Registration District No. 240
Primary Registration District No. 5-332

File No. _____
Registered No. _____
St. _____ Ward _____

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

3. SEX Fe 4. COLOR OR RACE Wh 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 10/28 A. Higgins REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 18 1928

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

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) _____, 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

Every item of information on this form is a permanent record. Every item of information should be stated EXACTLY. PHYSICIAN'S RECORD should be supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH is a fact, to be stated as such, and not as a term, to be stated as such. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

5-20255-1