

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

Do not use this space.

**1. PLACE OF DEATH**

County Monroe  
Township Jackson  
City Paris (No. \_\_\_\_\_)

Registration District No. 582  
Primary Registration District No. 4344

File No. 27963  
Registered No. 37  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

William Hutton

(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) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1859

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min. 67

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Day laborer (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) mo

10. NAME OF FATHER don't know

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT Elmer Hutton (Address) Moberly Mo.

15. FILED 8-31-1928 H.C. Payne REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/19 1928

17. I HEREBY CERTIFY That I attended deceased from Aug 12, 1928, to Aug 19 that I last saw him alive on Aug 15 death occurred, on the date stated above, at Paris

THE CAUSE OF DEATH\* WAS AS FOLLOWS: Influenza

CONTRIBUTOR (SECONDARY) IB (duration) yrs. mos. ds. 7

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_ WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) Geo. W. Ruppel (Address) Paris 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 Houteville Mo. DATE OF BURIAL 8-20-1928

20. UNDERTAKER Fred Thompson ADDRESS Madison Mo.

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.

1928



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

ALL INFORMATION REQUESTED  
 FOR MUST BE WRITTEN ON  
 THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County Monroe Registration District No. 382 File No. ....  
 Township ..... Primary Registration District No. 7344 Registered No. 37  
 City Paris (No. ....) St. .... Ward .....

**2. FULL NAME** William Hunter

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

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 St. known

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

14. INFORMANT (Address)

15. FILED 8-31-1928 N. C. Payne  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/19 19 28

17. I HEREBY CERTIFY, That I attended deceased from ..... to .....  
 that I last saw h..... alive on ..... 19..... and that death occurred, on the date above, at..... m.  
 THE CAUSE OF DEATH\* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) .... yrs. .... mos. .... ds.  
 (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

The following information is to be supplied: AGE should be stated EXACTLY. If age is unknown, it should be stated as "unknown". Exact statement of OCCUPATION, is very important. If the cause of death is a main term, so that it may be properly classified. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-27963