

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

Do not use this space.

35988

1. PLACE OF DEATH
 County Jasper Registration District No. 412 File No. _____
 Township _____ Primary Registration District No. 5570 Registered No. 6
 City Alba Mo. (No. _____) St. _____ Ward _____

2. FULL NAME Mr. John Derr
 (a) Residence No. _____ St. _____ Ward Alba Mo. R. R. # 1
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 1 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Mary Derr
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) October 5th. 1855
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
73 1

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

10. NAME OF FATHER Don't Know
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Don't Know
 12. MAIDEN NAME OF MOTHER Don't Know
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Don't Know

14. INFORMANT Mrs. Mary Derr.
 (Address) Alba Mo.

15. FILED 10/8-28 19 Charles E. Scafe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 6th. 19 28

17. I HEREBY CERTIFY, That I attended deceased from March 19.25 to Oct 6 1928
 that I last saw him live on Oct 6 1928, and that death occurred, on the date stated above, at 12-4 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

apoplexy
92167
8217 (duration) _____ yrs. mos. da.
 CONTRIBUTORY intest. Regulation
 (SECONDARY) (duration) _____ yrs. mos. da.

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) W. J. Hagan M. D.
1/8 1928 (Address) Webb City 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 Lamar Mo. DATE OF BURIAL 10/8 1928

20. UNDERTAKER Steele Und. Co. Webb City Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD
 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.

