

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

Do not use this space.

34433

1. PLACE OF DEATH

County *Ballwin*
Township *Ballwin*
City *Ballwin*

Registration District No. *685-*
Primary Registration District No. *59.09 B*

File No. *19*
Registered No. *23*
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred *15* yrs. _____ mos. _____ da. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR *R* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *2/15/1912*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
15 9 23

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Labourer*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Kennett Mo*
(STATE OR COUNTRY)

10. NAME OF FATHER *James Lindsay*

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

12. MAIDEN NAME OF MOTHER *Mary B. Thornton*

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

14. INFORMANT'S NAME *Dora B. Wright*
(Address) *Clarksville, Mo*

15. FILED *Nov 1 1928* *H. N. Treachway* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 7th 1928*

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____, 10 A. M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Accidental death by B. & O. train 2815 2nd in north

CONTRIBUTORY (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) *C. W. Davis* Foreman

(Address) *Bowling Green*

*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 *Kennett Cemetery* DATE OF BURIAL *Oct 8 1928*

20. UNDERTAKER *Harvey Lowell* ADDRESS *Clarksville*

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
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Pike Registration District No. 685 File No. 19
 Township Calumet Primary Registration District No. 3-9-04-B Registered No. 23
 City (No.) St. Ward)

2. FULL NAME Richard Lee Linsley
 (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** Cal **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Single

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 11.1.1928 H. W. ... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 7 1928

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

THE CAUSE OF DEATH WAS AS FOLLOWS:
Accidental death by
train near
near village near
Pike Co. Mo.

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
	19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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