

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

Do not use this space.

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**1. PLACE OF DEATH**

County Bollinger  
Township Paradox  
City Lutesville (No. ....)

Registration District No. 66  
Primary Registration District No. 5102 B

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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) ←

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 14 1911

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
17 11 17

**8. OCCUPATION OF DECEASED**

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

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

PARENTS

10. NAME OF FATHER Togan Bufard

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

12. MAIDEN NAME OF MOTHER Spill

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

14. INFORMANT Togan Bufard  
(Address) Lutesville

15. FILED 21 1929 J. J. Chandler  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 31 1929

17. I HEREBY CERTIFY, That I attended deceased from 9/9 1929, to 1/31 1929 that I last saw h. .... alive on ..... 19..... and that death occurred, on the date stated above, at 10:25 A.M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Carcinoma Intestines

CONTRIBUTORY (SECONDARY) 45 (duration) 1 yrs. 6 mos. .... ds.  
(duration) ..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH, .....

DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? .....

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

2/2, 1929 (Address) Lutesville 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 Myer DATE OF BURIAL Feb 2 1929

20. UNDERTAKER A. G. Baker ADDRESS .....

1929  
 1-3  
 Every important  
 CAUSE OF DEATH in plain text

1  
2  
3  
4

**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 Bollinger

Registration District No. 66

File No. ....

Township Luttrellville

Primary Registration District No. 8102 B

Registered No. ....

City Luttrellville (No. ....)

St. .... Ward)

**2. FULL NAME** James Nelson Bivford

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

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 ..... (duration) yrs. mos. ds.  
(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 3-1-29 J J Landes REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 31 1929

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

18. WHERE WAS DISEASE CONTRACTED (duration) yrs. mos. ds.  
PRIMARY.....  
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

Meyer Cemetery 19

20. UNDERTAKER ADDRESS

A J Barr 2/2-29

**SUPPLEMENTARY**

N. P.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE INFORMATION AS PRESCRIBED BY LAW

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