

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

Do not use this space.

2196

**1. PLACE OF DEATH**

County Laclede  
Township Lebanon  
City Lebanon (No. ....) St. .... Ward)

Registration District No. ....  
Primary Registration District No. 267

File No. ....  
Registered No. 15723  
St. .... Ward)

**2. FULL NAME**

James Archibald Vernon

(a) Residence No. .... St. .... Ward.

(Usual place of abode)  
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. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)  
Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 13-1855

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, <u>hrs.</u> or <u>min.</u>
<u>73</u>	<u>4</u>	<u>15</u>		

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) Linn Creek  
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Jas. Vernon

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

12. MAIDEN NAME OF MOTHER Harriet McCaleb

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

14. INFORMANT Mrs C.B. Burley  
(Address) Lebanon Mo.

15. FILED ..... 19..... REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-28-29 19

17. I HEREBY CERTIFY, That I attended deceased from Dec 24, 1929, to Jan 28, 1929 that I last saw him alive on 1/25/29 at 5.45 P., 19... and that death occurred, on the date stated above, at ..... m.

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

Myocarditis & Chronic Nephritis

CONTRIBUTORY (SECONDARY) 1290 (duration) yrs. mos. da.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) L.A. McCaleb, M.D.  
1/29, 1929 (Address) Lebanon, 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 Lebanon Mo. DATE OF BURIAL 1-30-29 19

20. UNDERTAKER Palmer ADDRESS Lebanon

K. 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.

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

1929  
53  
2  
6  
17  
1  
31  
31

100-100000

AGS should be made

if it is to be effective

100-100000

**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 Laclede Registration District No. 449 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 4267 Registered No. \_\_\_\_\_  
 City Lebanon (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

James Archibald Ferner  
 (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 W.  
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 13 1855

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 3/14 1929 J.M. Bellamy REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 28 1929 19

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

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

19

20. UNDERTAKER ADDRESS

Every item on this certificate is classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-2196