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

Do not use this space.

5139

1. PLACE OF DEATH
County Sullivan Registration District No. 85
Township Polk Primary Registration District No. 6120
City Near Milan (No. ..... St. ..... Ward)
File No. .....
Registered No. 3

2. FULL NAME William Black

(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)~~: Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 7th 1856

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	73	—	—	

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

PARENTS

10. NAME OF FATHER John Black
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Illinois
12. MAIDEN NAME OF MOTHER — Eads
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Illinois

14. INFORMANT William Black Jr
(Address) Milan Mo

15. FILED 1-7, 1929 Bertha McClain
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1929, to Jan 5, 1929, that last saw h— alive on Jan 2, 1929, and that death occurred, on the date stated above, at 2 o'clock a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia
101A
818
..... (duration) ..... yrs. ..... mos. 4 ds.
CONTRIBUTORY (SECONDARY) Barbiturism Suicidal
..... (duration) 2014 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) J. S. Montgomery, M. D
Jan 5, 1929 (Address) Milan 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: Oakwood Cem Milan Mo — DATE OF BURIAL: Jan 6 1929

20. UNDERTAKER O. F. Schaeue — ADDRESS Milan Mo

Any item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to fill out CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 Sullivan Registration District No. 85-2 File No.
Township Polk Primary Registration District No. 6129 Registered No. 3
City (No. St. Ward)

2. FULL NAME William D Lack

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

PARENTS
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 3-15-29 Bertha McClary
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5 1929

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 ....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia
Bronchs
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Flu
(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

SUPPLEMENTARY

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

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.

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