

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

Do not use this space.

5154

**1. PLACE OF DEATH**

County Taney Registration District No. 859  
 Township Brush Creek Oliver Primary Registration District No. 6130  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_

**2. FULL NAME**

Joe Clard Mead  
 (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**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 10<sup>th</sup> 1918

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
10 6 2

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) Reed Springs, Mo.  
 (STATE OR COUNTRY)

10. NAME OF FATHER John Mead

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

12. MAIDEN NAME OF MOTHER Maie Bennett

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

14. INFORMANT John Mead  
 (Address) Hollister Mo.

15. FILED 7/14/29 P. A. Thornhill  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) January 12<sup>th</sup> 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan 12<sup>th</sup> 1928 to Jan 12<sup>th</sup> 1928 that I last saw him alive on Jan 11<sup>th</sup> 1928, and that death occurred, on the date stated above, at 12:05 P.M.

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

Accident - shot self  
1897 with shotgun

**CONTRIBUTORY (SECONDARY)**

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH \_\_\_\_\_

0 DID AN OPERATION PRECEDE DEATH. No DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? None

(Signed) Harry T. Evans, M.D.

, 19 (Address) Hollister 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 DATE OF BURIAL

Edwards grave yard. Jan 13 1928

20. UNDERTAKER None ADDRESS \_\_\_\_\_

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

In Jan 1929  
ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County..... Waverly ..... Registration District No. 859 ..... File No. ....  
Township..... Clay ..... Primary Registration District No. 6130 ..... Registered No. ....  
City..... (No. ....) ..... St. .... Ward)

**2. FULL NAME**

(a) Residence No. Joe Claud Mead Sl. .... 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**

**MEDICAL CERTIFICATE OF DEATH**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 12 1929

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 10 - 1918

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min. 10 6 12

**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)

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)

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)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

15. FILED 1/14 29 R. Stormshel REGISTRAR

20. UNDERTAKER none ADDRESS

**SUPPLEMENTARY**

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

4-15-5