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

Do not use this space.

7041

1. PLACE OF DEATH

County LACLEDE — Registration District No. 449 — File No.

Township WASHINGTON — Primary Registration District No. 5612 — Registered No. 1527

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME JOHN GIVENS

(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	WIDOWER

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) NOV. 6 - 1839

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
89	3	10	

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) TENN.

PARENTS

10. NAME OF FATHER John Givens

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

12. MAIDEN NAME OF MOTHER Delora Bell

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

14. INFORMANT Etta Bennett
(Address) LEBANON Mo.

15. FILED 2/17, 1929 K M Billings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1928, to Feb 16 1929, that I last saw him alive on Dec - 15 1928, and that death occurred, on the date stated above, at 440 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Influenza and Pneumonia
108
131 (duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (SECONDARY)
V Ephritis (duration) ..... yrs. 2 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? Phys Exam Chem Exam

(Signed) T H Casey, M. D

, 19 (Address) Rebanon, 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
ROGERS ARK	Nob Pneumonia 19
20. UNDERTAKER	ADDRESS
PALMER	LEBANON

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County: Jackson Registration District No.: 449 File No.:
Township: Washington Primary Registration District No.: 3612 Registered No.:
City: (No. , St. Ward)

2. FULL NAME: John Givens
(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 (write the word): Wid
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 4/5 19 29 J M Billings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 16 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:
Influenza & Pneumonia
Lobar
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Mephitis Chronic
(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

FOR CERTIFICATES UNTIL THEY ARE CO
AS PRESCRIBED
TRAF

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