

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

Do not use this space.

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.

10
31929

File No. **9532**
Registered No. _____
St. _____ Ward)

1. PLACE OF DEATH

County Boone
Towship _____
City Columbia (No. _____)

Registration District No. _____
Primary Registration District No. _____

2. FULL NAME

John Willard Herring

(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)

Male | White | Single

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

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

Sept 27-1910

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

18 | 6 | 1 | _____

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Macon Co. Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER John Herring

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

12. MAIDEN NAME OF MOTHER Fannie Perkins

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

14. INFORMANT John Herring
(Address) Columbia Mo.

15. FILED 324 29 Leatrice Guss
19. _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Mar. 19 1929, to Mar. 28 1929, and that I last saw him alive on Mar. 28 1929, and that death occurred, on the date stated above, at 12:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Typhoid fever

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRAUGHT
IF NOT AT PLACE OF DEATH _____

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

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) W. P. Nyquist, M. D.

3/29, 1929 (Address) Columbia 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 Antioch, Macon Co Mo DATE OF BURIAL 3/31 1929

20. UNDERTAKER W. A. Vandewater ADDRESS Columbia Mo.

