

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

Do not use this space.

10460

1. PLACE OF DEATH

County Howell
Township _____
City Willow Springs, Mo.

Registration District No. 385

Primary Registration District No. 5536

File No. _____

Registered No. 113

St. _____ Ward _____

2. FULL NAME Henry P. Fair

(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

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-27-1929

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

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 _____ m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 23. 1885

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Head crushed by Automobile accident. One mile north of Willow Springs, Mo

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
44 7 5

CONTRIBUTORY (SECONDARY) 1880
(duration) _____ yrs. _____ mos. _____ ds.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stock Dealer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

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

9. BIRTHPLACE (CITY OR TOWN) Greenville
(STATE OR COUNTRY) Tenn.

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

10. NAME OF FATHER Sam Fair

WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) Tom Bales, Coroner
1929 (Address) West Plains, Mo

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

12. MAIDEN NAME OF MOTHER Marthy Fry.

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

*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.

14. INFORMANT Mrs Mont Jones
(Address) Oklahoma.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Hutton Valley DATE OF BURIAL 4/1/ 19 29

15. FILED 7/28 19 29 J. B. Ferguson REGISTRAR

20. UNDERTAKER W. R. Burns ADDRESS Willow Springs, Mo

46
25 1929
656
43
133
2
31
31

Exact statement of OCCUPATION is very important. Every item of information should be carefully separated. CAUSE OF DEATH in plain terms, so that it may be properly classified.

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Howell
Township
City Willow Springs (No. St. Ward)

Registration District No. 385-
Primary Registration District No. 4228

File No. 10460
Registered No. 23

2. FULL NAME

(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) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 22 - 1884

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
44 7 3-

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) (duration) yrs. mos. ds.
(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 6/10 1929 J.B. Ferguson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-27 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:

CONTRIBUTORY (SECONDARY) (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. Information should be carefully supplied. AG. See to be stated in plain terms, so that it may be properly classified. AG. See to be stated in plain terms, so that it may be properly classified.

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