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

Do not use this space.

11643

File No. 46

Registered No. ____

1. PLACE OF DEATH
County New Madrid Registration District No. 604
Township 11 11 Primary Registration District No. 5602
City ___ (No. ___, ___ St. ___ Ward)

2. FULL NAME James Dawson

(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. ___ da. How long in U.S., if of foreign birth? ___ yrs. ___ mos. ___ da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 23 1928

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ___ hrs. or ___ min.
		5	29	

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

9. BIRTHPLACE (CITY OR TOWN) New Madrid
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Watt Dawson
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ___
(STATE OR COUNTRY) Mo
12. MAIDEN NAME OF MOTHER Amelia Trotter
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ___
(STATE OR COUNTRY) Mo

14. INFORMANT Amelia Trotter
(Address) New Madrid

15. FILED 3/22/1929 W. O'Bannon
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 22nd 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 6 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lung trouble without Medical attention.

(duration) ___ yrs. ___ mos. ___ da.

CONTRIBUTORY (SECONDARY) ___

(duration) ___ yrs. ___ mos. ___ da.

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) W. O'Bannon, M. D
, 19 (Address) Co. Health Officer

*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 East Side Cem
DATE OF BURIAL 3-23rd 1929

20. UNDERTAKER Richards Und. Co
ADDRESS New Madrid

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.