

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

Do not use this space.

13501

1. PLACE OF DEATH

County Sesuit Registration District No. 1157
 Township Madison Primary Registration District No. 4589
 City Jandrew (No.) Sl. War

File No.
 Registered No.

2. FULL NAME

Esau W Blair

(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 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) Mar 13 1929

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

17. I HEREBY CERTIFY, That I attended deceased from 1-1, 1929, to 3-13, 1929 that I last saw him alive on 3-13, 1929, and that death occurred, on the date stated above, at 8:00 a.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 30 1840

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cardiac Insufficiency

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
87 1 14

CONTRIBUTORY (SECONDARY) Old age
 (duration) yrs. mos. ds.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired
 (b) General nature of industry, business, or establishment in which employed (or employer)

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

9. BIRTHPLACE (CITY OR TOWN) Weymouth Mass (STATE OR COUNTRY) Mass

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) Wm H. Burton, M. D.

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown 13-14, 1929 (Address) Jandrew Mo

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

*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 Glennie Hodges (Address) Saleado Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Carpenter DATE OF BURIAL 3/14 1929

15. FILED 3-14 1929 Wm H. Burton REGISTRAR

20. UNDERTAKER H. G. Belsch ADDRESS Saleado Mo

2
 1929
 89-1-13
 3

7
2

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Scott

Registration District No. 115-7

File No.

Township

Primary Registration District No. 45-89

Registered No.

City Vanduser (No.)

St. Ward)

2. FULL NAME

Geo W. Blair

(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

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)

Jan 30 - 1840

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

89

1

13

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)

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, 19 29

Wm J. Burton
REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/13 19 29

17.

I HEREBY CERTIFY That I attended deceased from to 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)

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

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

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement.

SUPPLEMENTARY

