

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

Do not use this space.

13742

PLACE OF DEATH
 County Adair Registration District No. 20
 Township Jarvis Primary Registration District No. 4014
 City Jarvis (No.) St. Ward

2. FULL NAME Thomas Wier

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 24 1843

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
85	5	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work City Collector

(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) Iowa

10. NAME OF FATHER Geo. Wier

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

12. MAIDEN NAME OF MOTHER Agnes Moffitt

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

14. INFORMANT (Address) Mrs. Thos. Wier Jarvis, Mo.

15. FILED Apr 8, 1929 Dr. C. M. Waugh REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 2 1929

17. I HEREBY CERTIFY, That I attended deceased from Mar 19 1929, to Apr 1 1929, that I last saw him alive on Apr 1 1929, and that death occurred, on the date stated above, at 2:20 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1867 Sepsis
1928 Sepsis
accident

(duration) 2 yrs. 2 mos. 2 da.

CONTRIBUTORY (SECONDARY) 10.0

(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? ✓

19. DID AN OPERATION PRECEDE DEATH no DATE OF ✓

20. WAS THERE AN AUTOPSY? no

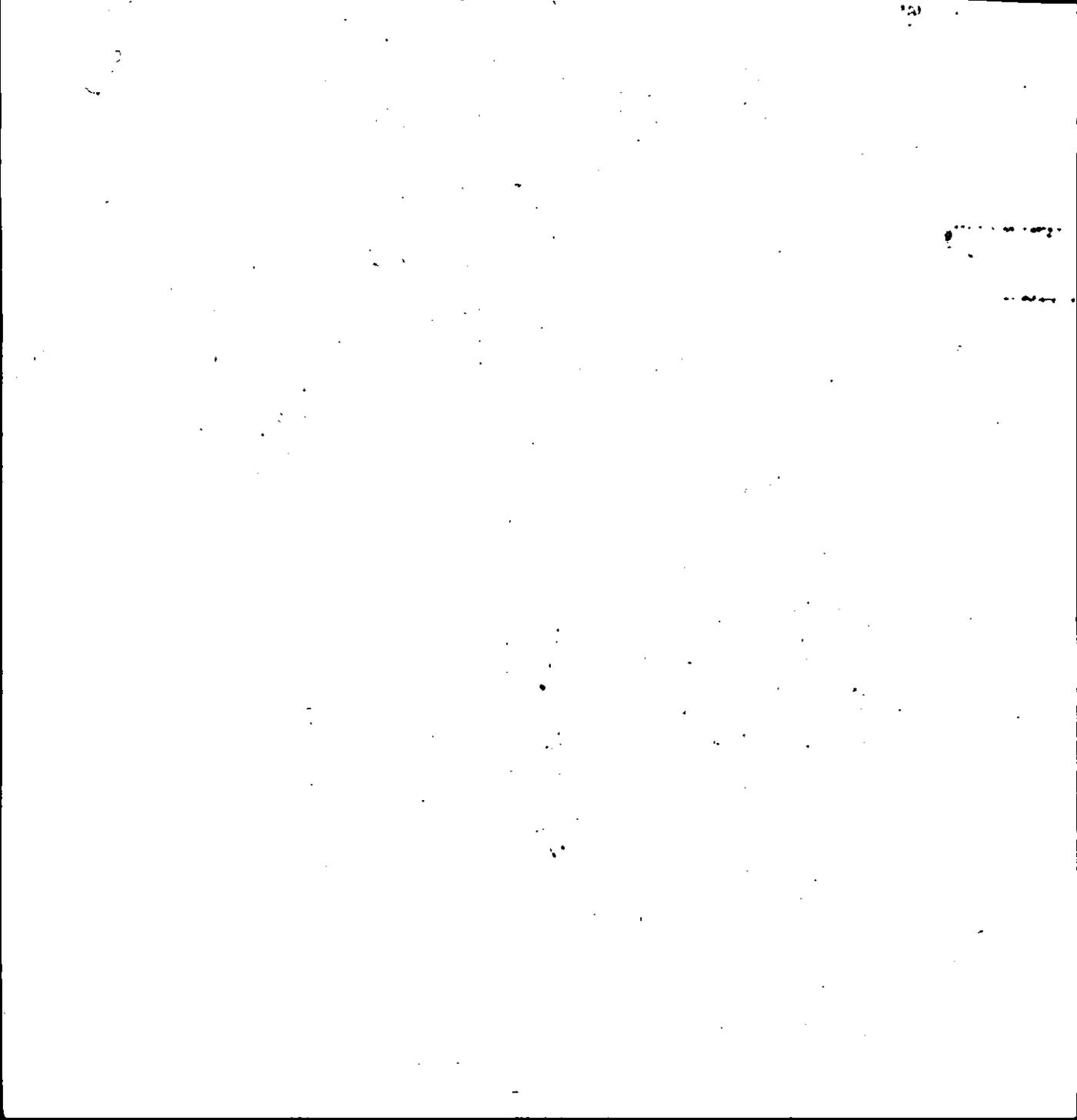
WHAT TEST CONFIRMED DIAGNOSIS? Clinical symptoms
apx 1929 (Address) Jarvis, Mo.

(Signed) C. M. Waugh, M. D.

*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 Home Cemetery **DATE OF BURIAL** Apr 4 1929

20. UNDERTAKER J. M. Davis **ADDRESS** Jarvis, Mo.



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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..... *Atchison* Registration District No..... *20* File No.....
Township..... Primary Registration District No..... *4014* Registered No.....
City..... *Tarkenton* (No.....) St..... Ward.....

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)

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. *W. M. Waugh* REGISTRAR
FILED *May 24, 1929*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Apr 2* 19 *29*

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.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Accident
Fall - fractured hip
(duration)..... yrs..... mos..... ds.
CONTRIBUTORY (SECONDARY) *Senility*
(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

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

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

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