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

Do not use this space.

14476

1. PLACE OF DEATH

County: Henry — Registration District No. 347 — File No.

Township: White Oak — Primary Registration District No. 5495 — Registered No. 59

City ..... (No. ..... St. ..... Ward)

2. FULL NAME: John Lewis Surface

(a) Residence. (Usual place of abode) No. ..... St. ..... Ward. ..... (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

NOV 25 1929

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
male	white	married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Mary Jane Surface

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan. 25, 1865

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
64	2	6	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(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): Jackson Co. Mo.

PARENTS

10. NAME OF FATHER: H. P. Surface

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

12. MAIDEN NAME OF MOTHER: Charlotte Campbell

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

14. INFORMANT: Mary Jane Surface (Address) Urich Mo

15. FILED Apr. 6 1929 Dr. E. C. Peelor REGISTRAR per JG

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Apr 1 1929

17. I HEREBY CERTIFY, That I attended deceased from Mar 28, 1929 to Apr 1, 1929 that I last saw him alive on Mar 31, 1929, and that death occurred, on the date stated above, at One A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Injury from falling out of wagon, causing general paralysis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (SECONDARY): 1885

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED: Home

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? None

(Signed) J. W. Galbreath, M. D

, 19 (Address) Urich 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	DATE OF BURIAL
Blairstown Cemetery	4-2 1929

20. UNDERTAKER	ADDRESS
T. H. Smith	Urich Mo

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.