

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

Do not use this space.

17095

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. N. E.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

MAY 29 1929

1. PLACE OF DEATH

County Worth
Township Union
City Grant City (No.)

Registration District No. 904
Primary Registration District No. 6213

File No.
Registered No.
St. Ward

2. FULL NAME

(a) Residence. No. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred Life expectancy yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 17, 1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min. 79 7 6

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Wagon Co. Ill.
(STATE OR COUNTRY)

10. NAME OF FATHER Cliff Morris

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

12. MAIDEN NAME OF MOTHER Kathryn Flood

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

14. INFORMANT Mrs. E. B. Murray
(Address) Grant City Mo.

15. FILED 4/8, 1929 J. W. High REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-3-1929 19

17. I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1928, to March 3, 1929 that I last saw him alive on Feb. 28, 1929, and that death occurred, on the date stated above, at 2:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocardial degeneration
Heart
101A
101B
101C
101D

CONTRIBUTORY (SECONDARY) Fractured femur (duration) 3 yrs. mos. ds.

(duration) 4 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

19. DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Physed under 90

(Signed) E. B. Murray, M. D.

, 19 (Address) Grant City 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

Grant City Cem. 4/6 1929

20. UNDERTAKER ADDRESS Grant City Mo.

Arch. C. Dumble

may be
replied to

at or before the time of the
meeting

**ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.**

File No......

Registered No.....

(No. _____ St. _____ Ward _____)

(If nonresident, give city or town and State)

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4 / 2 1999

17. 

I HEREBY CERTIFY. That I attended deceased from.....

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:

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or min.
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(c) **Name of employer**

10. NAME OF FATHER

12. MAIDEN NAME OF MOTHER

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

INFORMANT
(Address)

15.

FILED 6/8, 1909

REGISTRATION

CONTRIBUTORY (SECONDARY) *Fractured femur* *Co*

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

S-17095