

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

Do not use this space.

17433

1. PLACE OF DEATH

County Butler Registration District No. 480
Township Epps Primary Registration District No. 192
City..... (No..... St. Ward)

File No.....
Registered No.....

2. FULL NAME Joseph T. Daily

(a) Residence. No. 6 mi. west of P. B. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 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

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>widowed</u>
-----------------------	----------------------------------	--

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 19, 1872

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>56</u>	<u>5</u>	<u>10</u>		

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)..... Izard County
(STATE OR COUNTRY)..... Arkansas

10. NAME OF FATHER..... Andrew Daily

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

12. MAIDEN NAME OF MOTHER.....

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

14. INFORMANT..... Herbert Daily
(Address)..... 6 mi. west of P. B.

15. FILED 5/28/28 M. D. G. G. G.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 28, 1929

17. I HEREBY CERTIFY, That I attended deceased from May 27, 1929 to May 27, 1929, that I last saw him alive on May 27, 1929, and that death occurred, on the date stated above, at 9:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hepatic Abscess
31
..... (duration) yrs. 6 mos. ds.

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

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

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

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) A. W. Greer, M. D.

May 28, 1929 (Address) Poplar Bluff, 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..... Montgomery Cemetery DATE OF BURIAL..... May 30 1929

20. UNDERTAKER..... A. W. Greer Poplar Bluff, Mo.

24 1929
12
EXACTLY
FACT STATEMENT OF OCCUPATION
M. D. G. G. G.

**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 Butler

Registration District No. 980

File No.

Township Eppe

Primary Registration District No. 9132

Registered No.

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

2. FULL NAME

(a) Residence. No. Joseph I. Daily 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 <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>w</u>
--------------------	------------------------------	--

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 28 - 1929

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

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..... m.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day,hrs. ormin.
--------	-------	--------	------	--

Hepatic Abscess
probably Tubercular
(duration) yrs. mos. ds.

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.....

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

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

18. WHERE WAS DISEASE CONTRACTED

PARENTS

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)

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)

14. INFORMANT..... (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

15. FILED 7/15 1929 M. P. Bealman REGISTRAR

20. UNDERTAKER	ADDRESS
----------------	---------

SUPPLEMENTARY

Every item of information should be carefully supplied. AGE should be stated EXACTLY. MENSTRUATION should state CAUSE OF DEATH in full in German, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS ON, L. NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED 3: LAW

174833