

JUL 25 1929

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

Do not use this space.

21861

1. PLACE OF DEATH

County Hope Registration District No. 417
Township Hope Primary Registration District No. 3031
City Webb City, Mo. St. Mo. Ward

2. FULL NAME

(a) Residence. No. 1001 N. Nelson 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 23 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ___ hrs. or ___ min.
1 10 11

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Webb City, Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Tuel Harmon

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

12. MAIDEN NAME OF MOTHER Ester N E Mc

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

14. INFORMANT Tuel Harmon
(Address) Webb City, Mo.

15. FILED 6/20/29 R. M. Stormont
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 9 1929

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 _____, 6 P.M., m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Gastro-enteritis
1115 / 1315
(duration) yrs. mos. ds. 4

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

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

21. WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) J. L. Cray, M. D.
6/11, 1929 (Address) Webb 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 Mr Hope Co DATE OF BURIAL 6/11 1929

22. UNDERTAKER Webb City Used Co. ADDRESS W.C. Mo.

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.

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