

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.

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

Do not use this space.

24382

1. PLACE OF DEATH

County Greene  
Township Leonty  
City Rocky Dale (No. \_\_\_\_\_)

Registration District No. 320  
Primary Registration District No. 0443

File No. 9  
Registered 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 81 yrs. 7 mos. 1 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 (write the word) Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 21-1847

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
81 7 1 = min.

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) Greene Co. Mo.  
(STATE OR COUNTRY)

10. NAME OF FATHER Abraham Fine

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

12. MAIDEN NAME OF MOTHER May Harrison

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

14. INFORMANT Missie Miller  
(Address) \_\_\_\_\_

15. FILES 723 24 Lucy E. Hoyal  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-22-1929

17. I HEREBY CERTIFY That I attended deceased from Feb 24 to July 22, 1929  
that I last saw him alive on July 22, 1929, and that death occurred, on the date stated above, at 10:10 P. M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic Bronchitis  
99 106 B  
93 A  
(duration) 5 yrs. X mos. X da.  
CONTRIBUTORY Functional Heart Dis.  
(SECONDARY)  
(duration) ✓ yrs. ✓ mos. 15 da.

18. WHERE WAS DISEASE CONTRACTED At Home  
IF NOT AT PLACE OF DEATH: \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? Spinal Symptoms  
(Signed) B. F. Winkler, 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.  
7/23/1929 (Address) Box 106 No.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Prospect Cem 7/23/1929

20. UNDERTAKER ADDRESS

Rockham & Hoyal Box 106 No.

