JUL 26 1929

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

Do not use this space.

1. PLACE OF DEATH

County: Lafauette — Registration District No. 460 — File No. 25080

Township: — Primary Registration District No. 4274 — Registered No. 47

City: Higginsville, Mo. (No. ..... St. ..... Ward)

2. FULL NAME: James R. Medley

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

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: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): May 10th 1879

7. AGE: Years 50 — Months 1 — Days 25 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

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

(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): Scott County Va

PARENTS

10. NAME OF FATHER: Alfred Medley

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

12. MAIDEN NAME OF MOTHER: Harriot Quillin

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Scott Co. Va.

14. INFORMANT: Edward Medley
(Address) Higginsville, Mo.

15. FILED 27, 1929 Dessie P. Pitts REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 5 19

17. I HEREBY CERTIFY, That I attended deceased from only one visit, 19..., to ....., 19..., 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:

Pulmonary Tuberculosis

28 A

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): 31

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Place of death

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

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. F. Kroll, D.D.

, 19 (Address) Higginsville, 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: Odessa Cemetery

DATE OF BURIAL: July 7th 1929

20. UNDERTAKER: Ast Stader Higginsville Mo

ADDRESS

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.