

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

Do not use this space.

28344-B

**1. PLACE OF DEATH**

County Madison Registration District No. 038 File No. ✓  
 Township Frederickton Primary Registration District No. 3024 Registered No. ✓  
 City Frederickton (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 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 W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 10 - 1897

7. AGE 51 YEARS 10 MONTHS 14 DAYS  
 If LESS than 1 day,          hrs. or          min.

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

9. BIRTHPLACE (CITY OR TOWN) Grand River  
 (STATE OR COUNTRY) Illinois

10. NAME OF FATHER Louis C. You

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

12. MAIDEN NAME OF MOTHER Sarra Cheek

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Meriden, Conn.  
 (STATE OR COUNTRY) Mo.

14. INFORMANT Rhoda I You  
 (Address) Marquette Mo.

15. FILED 1-23-29 G. U. W. W.  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 27 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          m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

feet dentally run over by a truck  
BIOGE

CONTRIBUTORY (SECONDARY) It is our negligence  
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Aug 1929  
 IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH? viewed body DATE OF           
 WAS THERE AN AUTOPSY?           
 WHAT TEST CONFIRMED DIAGNOSIS?           
 (Signed) D. U. Davies M. D.  
 . 19          (Address) Frederickton

\*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 Cape Girardeau DATE OF BURIAL Aug 30 1929

20. UNDERTAKER E. C. You ADDRESS Marquette Mo.

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PARENTS

IMP

important. Example: *Measles* (disease causing death),  
9 ds.; *Bronchopneumonia* (secondary), 10 ds. Never  
port mere symptoms or terminal conditions, such as  
"Anemia," "Anemia" (merely symptomatic), "Atro-  
"Collapse," "Coma," "Convulsions," "Debility"  
"Fatal," "Senile," etc.), "Dropsy," "Exhaus-  
"Heart failure," "Hemorrhage," "Inanition,"

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Madison Registration District No. 538 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 5028 Registered No. \_\_\_\_\_  
 City Fredricktown (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

L. U. Yaw  
 (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 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 m  
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 10 - 1877

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

**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 \_\_\_\_\_

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

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) \_\_\_\_\_

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

15. FILED 23 19 30 C. U. Davis  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 27 19 29

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.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

accidental run over by auto truck - 2  
with white cap & hood  
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 1880  
 (duration) yrs. mos. ds.

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 \_\_\_\_\_

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-28344<sup>B</sup>