

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

Do not use this space.

29799

1. PLACE OF DEATH

County Shelby
Township North River
City Shelbyville (No.) St. Ward

Registration District No. 830
Primary Registration District No. 6891

File No. 34
Registered No.

2. FULL NAME Ernest Dow Courtney

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

White

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

single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 29 - 1915

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
13	8	17	

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) Shelbyville Mo.

10. NAME OF FATHER

Wm. Courtney

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER

Etta Taylor

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Shelbyville Mo.

14. INFORMANT

(Address) Wm. Courtney
Shelbyville Mo.

15. FILED

Sept 10 1929 Madge Wood
REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 12 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:

Death resulted from being struck by car, automobile. Fractured skull. Unavoidable accident.

No inquest deemed (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) necessary

(duration) yrs. mos. da.

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) E. P. Thompson Coroner, M. D.
, 19 (Address) Shelbyville, Mo.

*State the DISEASE CAUSING DEATH, or in death 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

J. B. Brothers Aug 13 1929

20. UNDERTAKER

ADDRESS

J. B. Brothers Shelbyville Mo.

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Shelby Registration District No. 830 File No. _____
 Township Ball River Primary Registration District No. 6091 Registered No. 34
 City _____ (No. _____ St. _____ Ward _____)

2. FULL NAME Ernest D. Courtney
 (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

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(write the word)

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 12 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.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Death resulted from being struck by auto. fractured skull. Moped St. Shelby, Mo. (Address) _____ yrs. mos. ds.
 (duration) _____ yrs. mos. ds.

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

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

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

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)

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) _____

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.

15. FILED Sept 10 29 Madge Lpoeh REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19____
 20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. Exact statement of OCCUPATION is very important.

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