

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

Do not use this space.

29987

**1. PLACE OF DEATH**

County Andrew Registration District No. 26  
Township..... Primary Registration District No. 3002  
City Wiggins, Mo. (No. ....) St. .... Ward)

File No. ....  
Registered No. 118

**2. FULL NAME** James Luma Glover

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

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

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** Feb. 17 - 1893

**7. AGE** YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
36 6 15

**8. OCCUPATION OF DECEASED**  
(a) Trade, profession, or particular kind of work Clerk in store  
(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) Callaway Co., Mo.

**10. NAME OF FATHER** J. R. Glover

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)** (STATE OR COUNTRY) Callaway Co., Mo.

**12. MAIDEN NAME OF MOTHER** Lillie Bailey

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)** (STATE OR COUNTRY) Callaway Co., Mo.

**14. INFORMANT** Wigand Glover  
(Address) Wiggins, Mo.

**15. DEPT. OF HEALTH** Sept 4, 1939 Ira S. Milligan REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Sept. 2, 1939

**17. I HEREBY CERTIFY**, That I attended deceased from ..... 19....., 19.....  
that I last saw him alive on ..... 19....., and that death occurred, on the date stated above, at ..... m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**  
gunshot wound  
falsely inflicted

**CONTRIBUTORY** None  
(SECONDARY) (duration) .... yrs. .... mos. .... da.

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

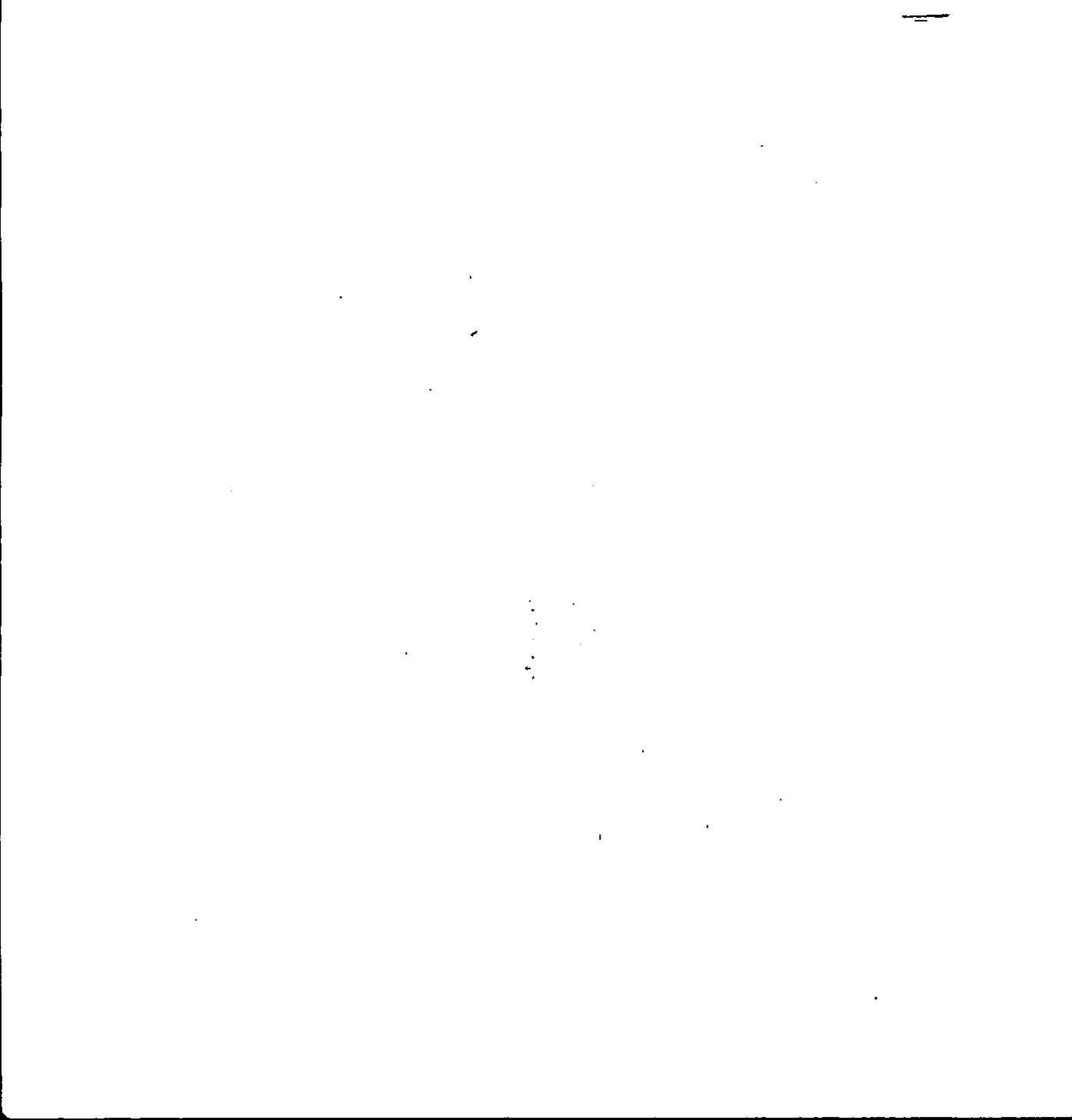
**DID AN OPERATION PRECEDE DEATH**..... DATE OF .....  
**WAS THERE AN AUTOPSY**..... No

**WHAT TEST CONFIRMED DIAGNOSIS**.....  
(Signed) E. Wood Bradford, M. D.  
, 19 (Address) Wiggins, 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** Paris Park - Callaway Co. **DATE OF BURIAL** Sept. 4, 1939

**20. UNDERTAKER** W. S. Spector Bros. **ADDRESS** Wiggins, Mo.



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Bedford

Registration District No. 26

File No. \_\_\_\_\_

Township \_\_\_\_\_

Primary Registration District No. 3002

Registered No. 118

City Merino (No. \_\_\_\_\_)

\_\_\_\_\_ (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 M 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (write the word)

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

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 \_\_\_\_\_

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. Sept 14, 1929 Ira A. Milligan  
FILED \_\_\_\_\_ REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 2 1929

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

that I last saw h. \_\_\_\_\_ all on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Gun shot wound feloniously inflicted by another man.  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTACTED \_\_\_\_\_

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 \_\_\_\_\_

SUPPLEMENTARY

THIS CERTIFICATE IS VALID ONLY WHEN COMPLETE AS PRESCRIBED BY LAW

5-29967