OCT 23 1929

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

Do not use this space.

30350

1. PLACE OF DEATH

County: Clark Jackson — Registration District No. 190 — File No.

Township: ~~[illegible]~~ — Primary Registration District No. 5274 — Registered No. 37

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Thos Chester Waples

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*)
Male	White	Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 17" - 1854

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	75	3	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(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) Cooper C. Ohio

PARENTS

10. NAME OF FATHER James Waples

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Cooper C. Ohio

12. MAIDEN NAME OF MOTHER Lambena Layland

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Cooper C Ohio

14. INFORMANT Chester Waples
(Address) Alexandria Mo

15. FILED Sep 18 29 J R Bridges REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 17 1929

17. I HEREBY CERTIFY, That I attended deceased from July 18, 1929, to Sept 17, 1929, that I last saw him alive on Sept 17, 1929, and that death occurred, on the date stated above, at 12:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
1079
1000
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Dat Kwon
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) F. A. S. Rebo, M. D.
Sep 18, 1929 (Address) Alexandria 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	DATE OF BURIAL
Bash Cemetery	Sept 20 1929
20. UNDERTAKER	ADDRESS
H. F. Kircher	Wagland Mo.

WRITE PLAINLY, WITH UNFADING

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.