

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

Do not use this space.

31109

408

3 PLACE OF DEATH
County Jaeger Registration District No. _____
Township _____ Primary Registration District No. 3020 Registered No. _____
City Carthage (No. Chapman Hospital St. _____ Ward) _____

2. FULL NAME George F. Fremont Southard
(a) Residence. No. Lawes Mill 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 (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-31-1890

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
39 7 26

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) Lawrence Co.
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Fremont Southard

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

12. MAIDEN NAME OF MOTHER Mattie Henshaw

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

14. INFORMANT G. F. Southard
(Address)

15. FILED 9/25 29 19. October 1929
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1929, to Sept. 27, 1929, that I last saw him alive on Sept. 27, 1929, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Albion's Disease
68 (Cause unknown)
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 68
(duration) _____ yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Genl. physical
(Signed) H. B. Chapman, M. D.
9/28/29 (Address) Carthage, 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 Red Oak DATE OF BURIAL 9-28-1929

20. UNDERTAKER J. H. Mounis & Leiman Miller 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.

RECORD

