

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

Do not use this space.

31176-291

1. PLACE OF DEATH

County Jefferson Co

Registration District No. 420

Township 22

Primary Registration District No. 5374

City Ladonia Mo (No.)

File No.

Registered No. 91

St. Ward)

2. FULL NAME Alfred Davis Atkinson

(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

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) Dec 7 1873

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>33</u>	<u>9</u>	<u>12</u>		

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) Jerryville Ill
(STATE OR COUNTRY)

10. NAME OF FATHER James Atkinson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Hallia Co Ohio
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Atkinson

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

14. INFORMANT Mrs. Cornelia Atkinson
(Address) Victoria Mo

15. FILED 423 29 D.L. Paugley

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
....., 19....., to 19.....
that I last saw him alive on Sept 17, 19....., and that death occurred, on the date stated above, at one a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy

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

Hypertension (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 Cornelius Ryan

(Signed) Atkinson, M. D.

, 19 (Address) Cornelius Ryan

*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 Victoria Mo Cemetery

DATE OF BURIAL Sept 20 1929

20. UNDERTAKER C.H. Barnhart

ADDRESS De Soto Mo

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.

17/11

17/11

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