

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

Do not use this space.

32903

1. PLACE OF DEATH

County Barry Registration District No. 29
 Township Flatrock Primary Registration District No. 4021
 City Cassville (No. _____) St. _____ Ward _____

File No. _____
 Registered No. 68

2. FULL NAME

Dovie Painter
 (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 <u>Fe</u>	4. COLOR OR RACE <u>Wh.</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>James T Painter</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Mar. 14th 1908</u>		
7. AGE	YEARS	MONTHS
	<u>28</u>	<u>7</u>
		DAYS If LESS than 1 day, _____ hrs. or _____ min.
		<u>9</u>
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <u>Housewife</u> 13		
(b) General nature of industry, business, or establishment in which employed (or employer) _____ 13		
(c) Name of employer _____		

MEDICAL CERTIFICATE OF DEATH

2
 16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-23-1929
 17. 1 I HEREBY CERTIFY, That I attended deceased from _____ 1929, to 10-23 1929
 that I last saw h. e. alive on 10-23 1929, and that death occurred, on the date stated above, at 7:20 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Hepatitis
 (duration) yrs. mos. ds. _____
 CONTRIBUTORY (SECONDARY) None
 (duration) yrs. 3 mos. 23 ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS Chimical
 (Signed) [Signature] _____, M. D.
 19 (Address) Cassville, 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.

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

PARENTS	10. NAME OF FATHER <u>Will. Auburn</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____
	12. MAIDEN NAME OF MOTHER <u>Rachel Emory</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT James T Painter
 (Address) Cassville, Mo

15. FILED Nov 19 29 Miss N. R. Williams
 REGISTRAR Dpt.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Ceter</u>	DATE OF BURIAL <u>10/24 1929</u>
20. UNDERTAKER <u>Horine Furniture & Funeral Service</u>	ADDRESS <u>Cassville</u>

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.

FADING INK—THIS IS A PERMANENT RECORD



**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 Barry

Registration District No. 29

File No.

Township

Primary Registration District No. 7021

Registered No. 68

City Cassville (No.)

St. Ward)

2. FULL NAME Dovie Painter

(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 <u>7</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M</u>
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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.
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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) Unknown

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED Jan 1 1930 Mrs N. R. Williams
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 23 - 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:

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

(duration) yrs. mos. ds.

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)

*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

PERMANENT RECORD

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-32903