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

Do not use this space.

36170-a

1. PLACE OF DEATH
County Wright — Registration District No. 1122 — File No.
Township Clark — Primary Registration District No. 6226 — Registered No. 12
City ..... (No. ..... St. ..... Ward)

2. FULL NAME Amos Caudle
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident, give city or town and State)
(Usual place of abode)
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 C
4. COLOR OR RACE
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 15, 1842

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
86	11	9	

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) N. C.

PARENTS
10. NAME OF FATHER — Caudle
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Va.
12. MAIDEN NAME OF MOTHER Unknow
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Unknown

14. INFORMANT N E Caudle
(Address) Norwood Mo.

15. FILED 10/10, 1929 T B Boulden REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 24 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 7, 1929 to Oct 21, 1929 that I last saw him alive on Oct 7, 1929 and that death occurred, on the date stated above, at 6 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Nephritis
131
102
..... (duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Infirmities of Age
..... (duration) ..... yrs. ..... mos. ..... 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? .....

(Signed) J W Hubbard, M. D.
1/9/30, 19 (Address) Mtn Grove 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 Caudle Cemetery
DATE OF BURIAL 10/25 1929

20. UNDERTAKER None
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.

JAN 21 '30

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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.

MISSOURI STATE BOARD OF HEALTH
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1. PLACE OF DEATH

County.................... Registration District No.................... File No....................

Township.................... Primary Registration District No.................... Registered No....................

City.................... (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

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (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)

PARENTS

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. FILED.............., 19.............. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) .... 19....

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:

....

....

.... (duration)......yrs.......mos.......ds.

CONTRIBUTORY (SECONDARY) .... (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
	19
21 UNDERTAKER	ADDRESS

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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

1. PLACE OF DEATH.

County: Wright — Registration District No.: 1122 — File No.:

Township: Clark — Primary Registration District No.: 6226 — Registered No.: 12

City: (No. ..., St. ..., Ward)

2. FULL NAME: Amos Candle

(a) Residence. No. ... St., ... Ward. (If nonresident give city or town and State)
(Usual place of abode)

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: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*): M

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)

PARENTS

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. FILED 11/10, 1929 — T B Boulden — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 24 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:

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (SECONDARY)

(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 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

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