

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

Do not use this space.

36342
35

1. PLACE OF DEATH

County Boone
Township Boonville
City Boonville (No.) St. Ward)

Registration District No. 79
Primary Registration District No. H.A.F. 7

File No.
Registered No.

2. FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Julia Coorwhite

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 27-1857

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	72	8	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired
(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) Mo.

PARENTS

10. NAME OF FATHER Robt. Coorwhite

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

12. MAIDEN NAME OF MOTHER Mary Ann Palmer

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

14. INFORMANT (Address) Mrs. Ella Sapier for Sturgeon Mo.

15. FILED 11/20, 1929 E. N. Lantry REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 19 - 1929
17. I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1929, to Nov. 19, 1929 that I last saw him alive on Nov. 19, 1929, and that death occurred, on the date stated above, at 3:35 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Uremic Poisoning
132A
136A
132B (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Obstructed Urterea (duration) yrs. mos. ds. 1 mo. 2 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH?

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) W. J. Johnson, M. D.
, 19 (Address) Sturgeon Mo

*State the DISEASE CAUSING DEATH, or in death 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

Mt. Pisgah Cem. Nov. 20 1929

20. UNDERTAKER ADDRESS Barnes F & U. Co. Sturgeon Mo

N. B.—Every item of information carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms. Let it may be properly classified. Exact statement of OCCUPATION is very important.

MAKING ERRORS IS A CRIME

**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 Boone Registration District No. 79 File No. 35
 County Boone Primary Registration District No. 7047 Registered No. _____
 Township _____ St. _____ Ward _____
 City Sturgeon (No. _____) St. _____ Ward _____

2. FULL NAME William Riley Crosswhite
 (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 m 4. COLOR OR RACE w 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) _____

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 11/26, 19 29 E. N. Gentry REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Wetate poisoning
Obstructed urethra
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) Obstructed urethra
 (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 _____

WRITE PLAIN INK--THIS IS A PERMANENT RECORD

PHYSICIANS should state item of information fully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. PATH in plain text. A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW SHALL NOT BE.

SUPPLEMENTARY

S-36342