

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

Do not use this space.

37897

**1. PLACE OF DEATH**

County Ray, Madril  
Township St. Louis  
City (No. \_\_\_\_\_) \_\_\_\_\_

Registration District No. 604  
Primary Registration District No. 8702

File No. 127  
Registered 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.

Mark Hatley

**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 addie Hatley

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 12 - 1894

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
<u>35</u>	<u>8</u>	<u>28</u>		

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Farming  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Carmelen Co. Mo.  
(STATE OR COUNTRY) Tennessee

10. NAME OF FATHER Grant Krum  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Grant Krum  
(STATE OR COUNTRY) \_\_\_\_\_  
12. MAIDEN NAME OF MOTHER Grant Krum  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Grant Krum  
(STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT T. W. Whitfield  
(Address) Stell MO

15. FILED 12/2/29 W. B. Amon REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 10 1929

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_, m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Stab wound of chest  
time with a left a medicine bottle  
behind timber through sub.  
(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? NO DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS?  
X (Signed) [Signature] Cassen  
, 19\_\_\_\_ (Address) Beart Pleasant, 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 Carmelen Tenn DATE OF BURIAL 4-12 1929

20. UNDERTAKER [Signature] ADDRESS Stell MO

PARENTS

JUL 1 1968

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BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County New Madrid  
Township Preserve  
City..... (No..... St..... Ward)

Registration District No. 604  
Primary Registration District No. 3803

File No.....  
Registered No.....

**2. FULL NAME**

Mark Hatley

(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 2/2/29 W. B. Cannon REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 10 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:**

Str. wound of chest  
Str. wound of chest  
..... (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

20. UNDERTAKER ADDRESS

THIS SHALL NOT RECEIVE A FEE OR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-37877