

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

Do not use this space.

✓ 40122

JAN 21 1930

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is also important. PHYSICIANS should state

PLACE OF DEATH
 County Boff Registration District No. 215
 Township Jefferson Primary Registration District No. 2017
 City Jefferson City (No. _____) St. _____ Ward _____
 2. FULL NAME Ulysses Bohannon
 (a) Residence. No. 207 Elm Washington St. Ward. _____ (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

MEDICAL CERTIFICATE OF DEATH

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 May Schubert
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 28-1869
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
61 7 21
 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) Worked mission Obispo Road House
 (c) Name of employer

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 19 29
 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929, to Dec 19, 1929
 that I last saw him alive on Dec 18, 1929, and that death occurred, on the date stated above, at 5:30 p.m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar Pneumonia
108
137
 (duration) yrs. mos. ds.
 CONTRIBUTORY Hypertrophied Prostate
 (SECONDARY) Prostate (duration) 7 yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri Mo.
 10. NAME OF FATHER James Bohannon
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Phelps Mo.
 12. MAIDEN NAME OF MOTHER Mary Wilson
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri

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? Cerebral
 (Signed) W. A. Clark, M. D.
12/14, 1929 (Address) Jefferson City Mo

14. INFORMANT May Bohannon
 (Address) Jefferson City Mo
 15. FILED 1/6 20 L. V. Bedford REGISTRAR

*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 New City Center DATE OF BURIAL 12/27 29
 20. UNDERTAKER James Samuel ADDRESS St. Mo

60

1

11

1953 MAR 10

151

DR. JOHN HARRISON

1000

1000

**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 Cole Registration District No. 213 File No. _____
 Township J. City Primary Registration District No. 3014 Registered No. 289
 City J. City (No. _____) St. _____ Ward _____

2. FULL NAME Ulysses Bohannon
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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) Apr 28-1869

7. AGE YEARS 60 MONTHS 7 DAYS 21 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 _____

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 19 19 29

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____ that I last saw him _____ alone 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.

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 1-6 1930 S. J. B. [Signature] REGISTRAR

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

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTERS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

S-40122