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

Do not use this space.

41526

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

1. PLACE OF DEATH
County New Madrid Registration District No. 605
Township Conran Primary Registration District No. 3-804
City Tiptonville (No. ....., ... St. ..... Ward)

2. FULL NAME G. W. Humphreys
(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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Sing.

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-28-28

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	10	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Malden Mo.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER G. G. Humphreys
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ky.
12. MAIDEN NAME OF MOTHER Mina Rose
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Mt Vernon Ill

14. INFORMANT G. G. Humphreys
(Address) Tiptonville

15. FILED 12/31, 1928 Mrs C. S. Blackman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-29 1928

17. I HEREBY CERTIFY, That I attended deceased from Dec 25, 1928, to Dec 30, 1928 that I last saw him alive on Dec 29, 1928, and that death occurred, on the date stated above, at 3:37 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
9
107A
(duration) ..... yrs. ..... mos. 6 ds.
CONTRIBUTORY (SECONDARY) W. Hooping Cough.
(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) Grayden Carlston 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
Parma Cem	12-31 1928
20. UNDERTAKER	ADDRESS
L McFee	Kilbourn

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD