

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
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

43296

1. PLACE OF DEATH

County Stoddard
Township Wetchell
City Grant City

Registration District No. 90 B
Primary Registration District No. 4540

File No. _____
Registered No. 23
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____
(Usual place of abode)

Length of residence in city or town where death occurred Life 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 Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 7, 1858

7. AGE YEARS MONTHS DAYS
71 10 23
If LESS than 1 day, hrs. 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) Indiana

10. NAME OF FATHER John Miller

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

12. MAIDEN NAME OF MOTHER Larinda Arnett

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

14. INFORMANT
(Address) Jesse Harris
Residing at home

15. FILED 1/6 19 20 John Chasars
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 30 19 29

17. I HEREBY CERTIFY, That I attended deceased from Nov 2, 1929, to Dec 30, 1929, that I last saw him alive on Dec 30, 1929, and that death occurred, on the date stated above, at Grant City, Mo.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heart insufficiency
GR
(duration) 2 yrs. mos. ds.

CONTRIBUTOR (SECONDARY) GR
(duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF 1/31

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Spinal fluid

(Signed) B. J. Mass, M. D.

, 19 29 (Address) Grant City, 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

DATE OF BURIAL

Middlefork Cem.

1/31 19 29

20. UNDERTAKER

ADDRESS

Arch C. Bungee

Grant City
Mo.

