

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

Do not use this space.

381

**1. PLACE OF DEATH**

County Callaway Registration District No. 109  
 Township Guthrie Primary Registration District No. 5162  
 City (No. ....) St. .... Ward)

File No. ....  
 Registered No. 467

**2. FULL NAME** Parker Nevins

(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 Black 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 25 1905

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
24 7 4

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Framer  
 (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) Missouri

10. NAME OF FATHER Peter Nevins

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

12. MAIDEN NAME OF MOTHER Georgia Holt

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

14. INFORMANT Columbus Nevins  
 (Address) Guthrie Mo

15. FILED 2/16 1930 C. M. Mark REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 29 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1930, to Jan 29 1930, that I last saw h. alive on Jan 29 1930, and that death occurred, on the date stated above, at 7:30 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Double Lobar Pneumonia

CONTRIBUTORY (SECONDARY) 10/10 108  
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH.....

Did an operation precede death? m. DATE OF.....  
 WAS THERE AN AUTOPSY? m.  
 WHAT TEST CONFIRMED DIAGNOSIS? clinical  
 (Signed) C. M. Mark M. D.  
424, 1930 (Address) North Bloomfield

\*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 Cal Chapel DATE OF BURIAL 1/30 1930

20. UNDERTAKER Ray A. Holt ADDRESS North Bloomfield

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.

