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

Do not use this space.

678

1. PLACE OF DEATH
County Dunklin — Registration District No. 283 — File No. 71
Township Buffaloe — Primary Registration District No. 5402 — Registered No.
City ..... (No. ..... St. ..... Ward)

2. FULL NAME William D. Lester
(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. 9 mos. 5 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): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-29-1929

7. AGE

| YEARS | MONTHS | DAYS | If LESS than 1 day, ..... hrs. or ..... min. |
|---|---|---|---|
| — | 9 | 5 | |

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) Buffalo Twp.
(STATE OR COUNTRY) Dunklin Co. Mo.

PARENTS

10. NAME OF FATHER W. D. Lester
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Hickman Co.
(STATE OR COUNTRY) Kentucky
12. MAIDEN NAME OF MOTHER Minnie Sanders
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Tennessee

14. INFORMANT W. D. Lester
(Address) Cardwell Mo.

15. FILED 1-4, 1930 [signature] REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-4 1930

17. I HEREBY CERTIFY That I attended deceased from Dec. 22, 1929 to Jan. 3rd, 1930 that I last saw him alive on Jan. 3rd, 1930, and that death occurred, on the date stated above, at 1 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia
10 TH
..... (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) Eli Back, M. D.
, 19 (Address) Cardwell 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: Cardwell Cemetery
DATE OF BURIAL: 1-5 1930

20. UNDERTAKER: Riggs Und. Co.
ADDRESS: Cardwell

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

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### CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Dunklin  Registration District No. 283  File No. .....

Township Buffalo  Primary Registration District No. 5402  Registered No. 71

City ..... (No. ....., ..... St. ..... Ward)

2. FULL NAME William D. Lester

(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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word) |
|---|---|---|
| M | W | S |

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)

PARENTS

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 1-4, 1930 E. J. Newsom
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 4 1930

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:
Pneumonia (Broncho)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 1000

(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 19 |
|---|---|
| 20. UNDERTAKER | ADDRESS |

SUPPLEMENTARY

N. B.—Every item [illegible] be carefully supplied. AGE should [illegible] CAUSE OF DEATH in [illegible] may be properly classified. Exact statement of [illegible]

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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