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

Do not use this space.

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1. PLACE OF DEATH
County: Dunklin — Registration District No. 283 — File No. 69
Township: Boggeo — Primary Registration District No. 5402 — Registered No.
City: ..... (No. ..... St. ..... Ward)

2. FULL NAME: L. J. Denton

(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	Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 25-1849

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	79	8	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) ..... (STATE OR COUNTY): Ala.

PARENTS
10. NAME OF FATHER: D.T.C.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTY): D.T.C.
12. MAIDEN NAME OF MOTHER: D.T.C.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTY): D.T.C.

14. INFORMANT: F. G. Denton
(Address): Cooter Mo

15. FILED 1-2, 1930 — [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan. 1st 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1929, to Dec. 31, 1929, that I last saw h. alive on Dec. 23, 1929, and that death occurred, on the date stated above, at 2 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tarcayoes —
E.R.D.
..... (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) [signature], M. D.
, 19 (Address) Cooter 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
Rescum	1/2nd 1930
20. UNDERTAKER	**ADDRESS**
Howard & Andrew	Cooter Mo

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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 Dunklin Registration District No. 283 File No. 69

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

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

2. FULL NAME L. J. Denton

(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	W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 25 - 1849

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ____ hrs. or ____ min.
	80	8	6	

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 1-2, 1930 [signature] Hawson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 1 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:
Paralysis of Central Nervous System
____ (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) ____, 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

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

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