

FEB 7 0 1930

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

Do not use this space.

2169

1. PLACE OF DEATH

County *Putnam*
Township *Cochran*
City *Cochran* (No.)

Registration District No. *64A*
Primary Registration District No. *5843*

File No.
Registered No.
St. Ward)

2. FULL NAME *William W. Ethridge*

(a) Residence No. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. *4* mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Mary E. Ethridge*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 10 1873*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ... hrs. or ... min.
57 3 26

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Farming*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *St. Albans station*
(STATE OR COUNTRY) *Missouri*

PARENTS

10. NAME OF FATHER *Henry Ethridge*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *don't know*
(STATE OR COUNTRY) *Missouri*

12. MAIDEN NAME OF MOTHER *don't know*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *don't know*
(STATE OR COUNTRY) *Missouri*

14. INFORMANT *Mrs. W. E. Ethridge*
(Address) *Cochran and*

15. FILED *2 10 1930* *John O. Jones*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *1 - 5 - 1930*

17. I HEREBY CERTIFY, That I attended deceased from *11 - 1 - 1929*, to *1 - 5 - 1930*, that I last saw *h.t.* alive on *1 - 1 - 1930*, and that death occurred, on the date stated above, at *11 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
930 (duration) yrs. *2* mos. *5* ds.

CONTRIBUTORY (SECONDARY) *none* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *none*
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *no* DATE OF *X*

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *none*
(Signed) *H. E. Cooper*, M. D.

6 - 1930 (Address) *Cochran, 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

Miss. Given Cemetery Mo *1 - 5 - 1930*
20. UNDERTAKER ADDRESS

German and Co *Starks Mo*

N. B.—Every statement supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

36-3-25

W. B. - Every one of later years is fully supplied. **CAUSE OF DEATH** is given, and so that it may be properly stated. The statement of the cause of death is very important.

**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 Deming Registration District No. 656 File No.
 Township Cooter Primary Registration District No. 2873 Registered No.
 City (No.) St. Ward)

2. FULL NAME William W Ethridge
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 10 - 1873

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
56 1 3 25 X

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 5 - 1930

17. I HEREBY CERTIFY, That I attended deceased from 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:

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)

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

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 2-10-30 Jones & Jones REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL 19.....

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

N. B. - Every item of information on above is carefully supplied. AGE should be sex. FULLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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