

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

Do not use this space.

Russell
7604-1

7604-1

1. PLACE OF DEATH

County Barry
Township Month
City Paul Vincent (No.)

Registration District No. 30
Primary Registration District No. 5040

File No. _____
Registered No. 41
St. _____ Ward) _____

2. FULL NAME

Paul Vincent

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

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. (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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 18, 1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
72 4 19

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer.
(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) Italy

10. NAME OF FATHER Bert Vincent

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

12. MAIDEN NAME OF MOTHER Mary Bonina

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

14. INFORMANT Henry Arndt
(Address) _____

15. FILED 7-16-19-30 W.M. West
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 17, 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1930, to March 17, 1930 that I last saw him alive on 3/16, 1930 and that death occurred, on the date stated above, at 325 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza
11/11/10 (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 DISEASE? Physical feeding
(Signed) W. M. West, M. D.

(Address) Waldensian

*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 Waldensian DATE OF BURIAL 3-19-1930

20. UNDERTAKER Blansenshuf ADDRESS Purdy

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.

CERTIFICATE OF DEATH—THIS IS A PERMANENT RECORD

