MAY 23 1930

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

Do not use this space.

12148

1. PLACE OF DEATH
County: Dade
Township: SaC
City: (No. ..... St. ..... Ward)
Registration District No.: 1109
Primary Registration District No.: 5-333
File No.: 1
Registered No.: 1

2. FULL NAME: Aaron Depee
(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: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

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

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

7. AGE: 82 YEARS | MONTHS: 1 | DAYS: 21 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

PARENTS
10. NAME OF FATHER: Don't Know
11. BIRTHPLACE OF FATHER (CITY OR TOWN): don't know
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER: Don't Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): don't know
(STATE OR COUNTRY)

14. INFORMANT: Mrs. W. G. Wilson
(Address): Greenfield, Mo.

15. FILED 5-10, 1930 O. A. Hembree
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): April 21 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 2:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralysis
82D
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY)
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) O. V. Hembree, M. D.
8-4, 1930 (Address) Greenfield 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: Friend Cemetery
DATE OF BURIAL: April 22 1930

20. UNDERTAKER: Will Meze, Dadeville, Mo
ADDRESS

N. B.—Every ... supplied. AGE ... state ... may be properly classified. ... important.
CAUSE OF DEATH ...

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 Dade — Registration District No. 1109 — File No.

Township Sac — Primary Registration District No. 5333 — Registered No. 1

City (No. , St. Ward)

2. FULL NAME Aaron Depee

(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	Wid

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.
	82	1	21	

OCCUPATION OF DECEASED

I don't know birth Date
I have no way of finding out
Please state
Kind of paralysis, Please fill in date of birth

14. INFORMANT (Address)

15. FILED 5-11 19 I A Hembree REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 21 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 Acute

(duration) yrs. mos. ds.

BUTORY (DARY) (duration) yrs. mos. ds.

RE WAS DISEASE CONTRACTED

NOT AT PLACE OF DEATH?

AN OPERATION PRECEDE DEATH? DATE OF

THERE AN AUTOPSY?

T TEST CONFIRMED DIAGNOSIS?

(Signed) , M. D

, 19 (Address)

te the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) ...ANS 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

ENTARY

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...ITEM OF INFORMATION SHOULD BE CARE... ...should be stated EXACTL... PHYSICIANS shoul... N. B.—Ever... plain terms, so that it ...fully supplied. AGE ... ...ment of O... ...TION is ver... ...ld state CAUSE OF D... ...lassified. ...OCCUPA... ...important.

REGISTRARS ... ...ES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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