

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

Do not use this space.

18458

1. PLACE OF DEATH

County North
Township Middlefork
City Grant City (No. 111-2)

Registration District No. 111-2
Primary Registration District No. 6213

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

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

Length of residence in city or town where death occurred yrs. mos. 8 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) Single

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
74

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Oil stock &
(b) General nature of industry, business, or establishment in which employed (or employer) Boat salesman
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Kentucky

PARENTS

10. NAME OF FATHER Charles Costin

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

12. MAIDEN NAME OF MOTHER Rachel Chapman

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

14.

INFORMANT John Costin
(Address) Grant City, Mo.

15.

FILED 6/2 1930 G. Andrews
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 31 1930

17. I HEREBY CERTIFY, That I attended deceased from May 25 1930 to May 31 1930 that I last saw him alive on May 25 1930, and that death occurred, on the date stated above, at 1 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer
53F
66A (duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) J. A. Hipp, M. D.

May 31 1930 (Address) Grant City, 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

Smithton, Mo. 6/1 1930

20. UNDERTAKER Arch C. Dumble ADDRESS Grant City

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.

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1908

REPORT OF THE

THE STATE OF NEW YORK
IN SENATE
JANUARY 1, 1908
REPORT OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
MAY 1, 1907
ALBANY: J.B. LIPPINCOTT & CO. PRINTERS
1908

**ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.**

1. PLACE OF DEATH.

County Worcester Registration District No. 11 File No.
Township Middlefork Primary Registration District No. 6213 Registered No.
City Worcester (No. 0) St. Ward

2. FULL NAME

(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)
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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.
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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)

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)

152

FILED... 19...

REGISTRATION

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 31 1930

17. I HEREBY CERTIFY, That I attended deceased from 19....., 19....., to 19....., 19....., and that I last saw b. alive on 19....., and that death occurred, on the date and place above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY.....
(SECONDARY)

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. I.
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

20. UNDERTAKER

ADDRESS

S-18458