

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

Do not use this space.

18887

1. PLACE OF DEATH

County Cass
Township Oldwater
City Drevel (No. _____ St. _____ Ward)

Registration District No. 151
Primary Registration District No. 4085

File No. _____
Registered No. 6

2. FULL NAME

Valentine Wilburn

(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

Maudie Wilburn

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

Aug 4 - 1861

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>68</u>	<u>10</u>	<u>19</u>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Ind

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 Mrs Maudie Wilburn
(Address) Drevel Mo

15.

FILED 6-27-30 J. M. Bundy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June - 25 - 1930

I HEREBY CERTIFY, That I attended deceased from Jan - 28, 1930, to Jan - 28, 1930 that I last saw him alive on Jan 28, 1930, and that death occurred, on the date stated above, at 7:05 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy
72
97 (duration) 4 yrs. 3 mos. ds.
CONTRIBUTORY Arterio Sclerosis
(SECONDARY) (duration) 10 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Observation & Phys Exam
(Signed) E. P. Phillips M. D.

6-26-1930 - (Address) Paola Kans.

*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

Sharon Cemetery

DATE OF BURIAL

6-27 1930

20. UNDERTAKER

J. M. Bundy

ADDRESS

Drevel Mo.

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 Blvd
Instructor

also

ET

**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 Cass Registration District No. 151 File No. _____
 Township Drexel Primary Registration District No. 4085 Registered No. 6
 City Drexel (No. _____) St. _____ Ward _____

2. FULL NAME Valentine Wilburn
 (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) _____

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.

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) June 25 19 30

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:

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) unknown

10. NAME OF FATHER unknown

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT _____ (Address) _____

15. FILED June 26 30 John S. Runk REGISTRAR

*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 _____

of information should be stated EXACTLY. PHYSICIANS should state age in plain terms, so that it is classified. Exact statement of OCCUPATION is very important. P.S. SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

