

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

Do not use this space.

19974
99

1. PLACE OF DEATH
 County Franklin Registration District No. 509
 Township Greene Primary Registration District No. 7677
 City Henry L. Carry St. _____ Ward _____
 File No. _____ Registered No. _____
 (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 divorced
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 27 - 1859
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
71 71 1 9
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Fanner
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

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

10. NAME OF FATHER Amos Carry
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) France
 12. MAIDEN NAME OF MOTHER Mary L. Bidan
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ohio

14. INFORMANT Charles Carry
 (Address) Childs
 15. FILED 7-9-30 D. B. Goff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Amos 1930
 17. I HEREBY CERTIFY, That I attended deceased from _____ to _____
 that I last saw Amos alive on June 7 30 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arteriosclerotic heart disease
22A
930
 (duration) one yr yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Arteriosclerotic
 (duration) 6 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED at place of death
 NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical examination
from Dr. Peoples
 (Signed) _____ M. D.
 _____ 19 _____ (Address) Chicago

*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 May cemetery DATE OF BURIAL 6-10-30

20. UNDERTAKER Amos D. Goff ADDRESS Childs

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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