AUG 20 1930

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

Do not use this space.

21841

1. PLACE OF DEATH

County: Barry — Registration District No.: 30 — File No.:

Township: Monett — Primary Registration District No.: 5040 — Registered No.: 44

City: (No. ... St. ... Ward)

2. FULL NAME Hewlow Montgomery

(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 One 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)
Male	white	widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 22

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ... min.
	75	8	8	

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) (STATE OR COUNTRY): Monett Mo

PARENTS

10. NAME OF FATHER: Wm Montgomery
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Dont Kn
12. MAIDEN NAME OF MOTHER: Mahaiby
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): U S A

14. INFORMANT: Robt Watkins
(Address): Purdy Mo

15. FILED 7-31, 1930 W. M. West REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 30 1930

17. I HEREBY CERTIFY, That I attended deceased from July 30, 1930, to July 30, 1930 that I last saw him alive on July 30, 1930, and that death occurred, on the date stated above, at 5 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Colitis
120B

(duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (SECONDARY) 114B

(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? Physical Feeling

(Signed) [signature] M.D.
7/31, 1930 (Address) Monett 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
Mars. Hill Cem	7-31 1930

20. UNDERTAKER	ADDRESS
Ernest Hilton	Crane 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.

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: Barry — Registration District No.: 30 — File No.:

Township: Monett — Primary Registration District No.: 3740 — Registered No.: 44

City: (No. St. Ward)

2. FULL NAME Newton Montgomery

(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	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) Oct 22 -

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
75		8	

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)

PARENTS
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)

15. FILED 9.10.1920 W. M. West
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 3d 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:

(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 DIAGNOSIS?
(Signed), M. D
, 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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should be stated EXACTLY. PHYSICIANS should be careful to write AGE in full. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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