OCT 30 1930

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

1. PLACE OF DEATH

County: Monroe — Registration District No.: 586 — File No.: 36573

Township: Santa Fe — Primary Registration District No.: 5784 — Registered No.: 64

City: Santa Fe (No. ..... St. ..... Ward) 60

2. FULL NAME John J. Talley

(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)
Male	White	Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feb. 20, 1846

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, ... hrs. or ..... min.
	84	7	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired 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): Mo

PARENTS

10. NAME OF FATHER: Berry Talley
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY): Va
12. MAIDEN NAME OF MOTHER: Patsy Simon
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY): Va

14. INFORMANT: E M Talley (Son)
(Address): Santa Fe Mo

15. FILED: Oct 11, 1930 — Minnie Drake, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 9-30 1930

17. I HEREBY CERTIFY, That I attended deceased from 8-6 1930 to 9-29 1930, that I last saw h. alive on 9-29 1930, and that death occurred, on the date stated above, at 8:10 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
~~Acute~~ Lobar Pneumonia (Typoslatic)
108 [illegible] (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (SECONDARY): Cronic Valvular Heart Lesion (duration) unknown yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? Residence
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? no. DATE OF ..... mm
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) B. A. Reynolds M.D.
, 19 (Address) Santa Fe

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Santa Fe Mo — DATE OF BURIAL: Oct 1st 1930

20. UNDERTAKER: Snyder & Hanger — ADDRESS: Santa Fe 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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(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)

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

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....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSIC
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is

V. S. No. 2.