OCT 30 1930

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

Do not use this space.
30591

1. PLACE OF DEATH
County: Morgan
Township: Haw Creek
City: ..... (No. ....., ... St. ..... Ward)
Registration District No.: 919
Primary Registration District No.: 5793a
File No.:
Registered No.: 87

2. FULL NAME: Samuel Newton Branch

(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: 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~~ Lucy M Branch

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sept 4 1852

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
78	0	11	

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): Calloway Co Mo

PARENTS
10. NAME OF FATHER: Jefferson Branch
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Virginia
12. MAIDEN NAME OF MOTHER: Polly
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Tennessee

14. INFORMANT: Wm Branch
(Address): Stover Mo

15. FILED Oct 10 1930 Chas. Piperger REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept 15 1930

17. I HEREBY CERTIFY, That I attended deceased from July 1930, to Sept 15 1930, that I last saw ~~a.m.~~ alive on Sept 15 1930, and that death occurred, on the date stated above, at 15 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of Liver
Hx E
(duration) yrs. 3 mos. ds.

CONTRIBUTORY (SECONDARY) 146
(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?
(Signed) Chas D Treat, M. D
Sept 16, 1930 (Address) Stover 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: Bulle Cem. Calloway Co Mo
DATE OF BURIAL: Sept 17 1930

20. UNDERTAKER: C. R. Rapp
ADDRESS: Stover Mo

Art. 5. 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.