

NOV 3 1930

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

Do not use this space.

1. PLACE OF DEATH

County Madison
Township Union
City Madison (No. _____) St. _____ Ward _____

Registration District No. 887
Primary Registration District No. 6182

File No. 31956
Registered No. 73

2. FULL NAME

Joseph N Bequett
(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 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 Emma Bequett

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-7-1848

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
81 9 73

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Old Mines
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Joseph Bequett

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Old Mines
(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Phelista Boursaw

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Old Mines
(STATE OR COUNTRY) Mo

14. INFORMANT Lemmie Bequett
(Address) Osage Mo R. 1

15. FILED 10-2-30 W. L. Thurman
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 9-20-30, 1930, to 9-29-30, 1930, that I last saw him alive on 9-29-30, 1930, and that death occurred, on the date stated above, at 11 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephritis
133 (duration) yrs. mos. da.
CONTRIBUTORY (SECONDARY) Chronic Nephritis
(duration) 2 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED 1290

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) H. F. Crisswell, M. D.

, 1930 (Address) Peter 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 Old Mines Mo DATE OF BURIAL 10/1 1930

20. UNDERTAKER W. Boyer Son ADDRESS P. O. Box

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.

