NOV 24 1930

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

Do not use this space.

32734

1. PLACE OF DEATH
County Howard — Registration District No. 380
Township Franklin — Primary Registration District No. 5530
City ..... (No. ..... St. ..... Ward)

File No. .....
Registered No. 26

2. FULL NAME William L. Mock

(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): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 21-1866

7. AGE: Years 63 — Months 10 — Days 5 — If LESS than 1 day, ... hrs. or ..... min.

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) Charlton Co
(STATE OR COUNTRY) Mo

PARENTS
10. NAME OF FATHER Samuel Mock
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ohio
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Matilda Sterman
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ?
(STATE OR COUNTRY)

14. INFORMANT Mrs Wm Mock
(Address) Franklin Mo

15. FILED 10-26, 1930. J. B. Fleck REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 26 1930

17. I HEREBY CERTIFY, That I attended deceased from July 5th, 1930, to Oct 26, 1930 that I last saw him alive on Oct 24, 1930, and that death occurred, on the date stated above, at 7 30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Disease of Heart
131
72 A
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Chronic Nephritis
(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) R. L. Evans, M. D
64 25th, 1930 (Address) Boonville 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: Walnut Grove Cem Boonville Mo — DATE OF BURIAL: 10/28 1930

20. UNDERTAKER: Goodman & Boller — ADDRESS: Boonville Mo

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.