

NOV 26 1930

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

Do not use this space.

1. PLACE OF DEATH

County *Miller*Registration District No. *562*Township *Ashwood*Primary Registration District No. *5757*

City (No. _____) _____

File No. *33565*

Registered 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

male

4. COLOR OR RACE

white

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) *Oct 22 - 1930*

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ or _____

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) *Miller Co Mo*

(STATE OR COUNTRY)

10. NAME OF FATHER *Wesley W Livingston*11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Miller Co Mo*

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Mildred E. Wade*13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Miller Co Mo*

(STATE OR COUNTRY)

14. INFORMANT *Wesley Livingston*(Address) *Iberia Mo*15. FILED *Nov 7, 1930* *W. A. and Gremp*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 23 1930*

17.

I HEREBY CERTIFY, That I attended deceased from *Oct 22* 19*30*, to *Oct 23* 19*30*, and that I last saw him alive on *Oct 23* 19*30*, and that death occurred, on the date stated above, at *10:40* a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*White Asphyxia**H.A.* (duration) _____ yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

16 (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) *W. A. and Gremp*, M. D.*23, 1930* (Address) *Iberia Mo*

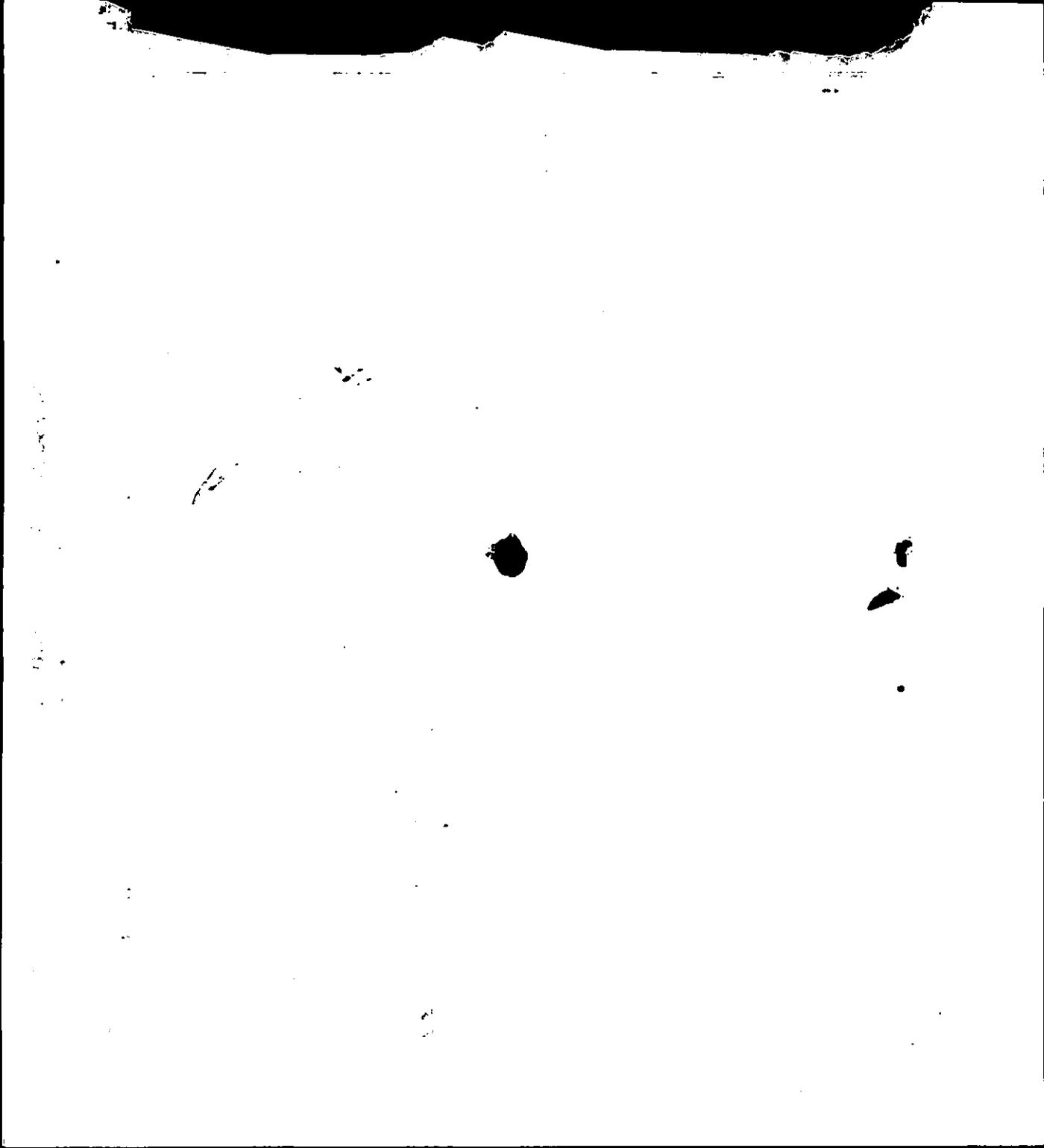
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Hickory Point Cem DATE OF BURIAL *Oct 24 1930*

20. UNDERTAKER

Adams & Casey ADDRESS _____state
portantA. B. -
CAUSE OF



**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 Miller Registration District No. 562 File No. _____
 Township Richard Primary Registration District No. 5-757 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

unnamed Livingston
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 22 1930

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
W 13 hrs

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

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 12/5 1930 W.A. von Gump REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 23 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.
 _____ (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

20. UNDERTAKER

ADDRESS

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.

:AW

THEY

REGISTRARS

SUPPLEMENTARY

S-33565