

NOV 28 1930

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

Do not use this space.

35106

1. PLACE OF DEATH

County Stoddard
Township Wink
City (No. _____) St. _____ Ward _____

Registration District No. 834
Primary Registration District No. 6097

File No. _____
Registered No. 33

2. FULL NAME

William Augustus Little
(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 Mrs. Sarah A. Little

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 17, 1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
74 8 1

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Berryville
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Little

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Don't know
(STATE OR COUNTRY)

14. INFORMANT Wm E. Little
(Address) 204 1/2 Bellevue, Detroit Mich

15. FILED 10-22-49 30 C. M. McReary
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 18 1930

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1 1930 to Oct. 18 1930, that I last saw him alive on Oct. 18 1930, and that death occurred, on the date stated above, at 10 55 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) John Wilson M. D.

(Address) Bell City, 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 Perkins Mo. DATE OF BURIAL Oct. 19 1930

20. UNDERTAKER F. Conington ADDRESS Bell City, 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.

