

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.

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

Do not use this space.

35988

1. PLACE OF DEATH

County HowellRegistration District No. 389Township MyattPrimary Registration District No. 3543City Myatt (No.)File No. 11Registered 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 <u>M</u>	4. COLOR OR RACE <u>Wht</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (give the word) <u>Widow</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 12-1866

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, <u> </u> hrs. or <u> </u> min.
<u>65</u>	<u>11</u>	<u>2</u>	<u> </u>	<u> </u>

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)

(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(STATE OR COUNTRY)

14.

INFORMANT
(Address)

15.

FILED

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 14 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 22, 1930, to Nov 14, 1930, that I last saw him alive on Nov 14, 1930, and that death occurred, on the date stated above, at a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Typhoid Fever
131 (duration) yrs. mos. ds. 25

CONTRIBUTORY (SECONDARY)

(duration) 4 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

NOT A PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. H. Thompson, M. D., 19 (Address) Lanton 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

DATE OF BURIAL

State Line Ark Nov 15 1930

20. UNDERTAKER

ADDRESS

None

