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

PLACE OF DEATH
County Wright
Township Mont. Grove
or
Village
or
City Mont. Grove (NO. ____ St. ____ Ward)

Registration District No. 908 (45-49-22)
Primary Registration District No. ____

File No. 38389
Registered No. 48

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Christopher C. Atkinson

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M	W	Married

DATE OF BIRTH: May 10, 1854 (Month) (Day) (Year)

AGE: 76 yrs. 6 mos. 5 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer 94
(b) General nature of industry, business, or establishment in which employed (or employer): 756 916

BIRTHPLACE (City or town, State or foreign country): Missouri

PARENTS
NAME OF FATHER: Daniel Atkinson
BIRTHPLACE OF FATHER (City or town, State or foreign country): Illinois
MAIDEN NAME OF MOTHER: - - - - Boatman
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Jos Walker
(ADDRESS) Mtn Grove Mo

Filed 11/20, 1930 J. M. Hubbard REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Nov 15 (Month) (Day), 1930 (Year)

I HEREBY CERTIFY, that I attended deceased from Aug 1, 1930 to Nov 15, 1930 that I last saw h live on Nov 14, 1930 and that death occurred, on the date stated above, at 12:10 m.

The CAUSE OF DEATH* was as follows:

Cystic Renal Disease
Yrs - More than 3
(Duration) ____ yrs. ____ mos. ____ ds.
Contributory (SECONDARY) Gangrene of foot
(Duration) ____ yrs. 2 mos. 15 ds.

(Signed) Edward Ott M. D.
11/19, 1930 (Address) Mtn Grove Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.
Where was disease contracted if not at place of death? ____
Former or usual residence Mtn Grove

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hillcrest Cemetery	11-18, 1930
UNDERTAKER	ADDRESS
Bartlett Funeral Home	Mt Grove

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PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....
or
Village..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ..... St.: ..... Ward)

[If death occurred in a hospital or institution give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1..... (Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191.... (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased fro

....., 191...., to....., 191....

that I last saw h..... alive on....., 191....

and that death occurred, on the date stated above, at.....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....d

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....d

(Signed)..... M.

....., 191.... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, sta
(1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191....
UNDERTAKER	ADDRESS