

DEC 20 1930

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

Do not use this space.

1. PLACE OF DEATH

County AdairRegistration District No. 2File No. 38401

Township _____

Primary Registration District No. 4004Registered No. 17City Hanniger (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)

Child

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

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

May 31, 1920

7. AGE

YEARS

MONTHS

DAYS

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

1062

8. OCCUPATION OF DECEASED

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

School child

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

Schooling

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Adair Co Mo

10. NAME OF FATHER

Wesley Wellbaum

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Adair Co Mo

12. MAIDEN NAME OF MOTHER

Minnie Shoof

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Adair Co Mo

14.

INFORMANT Wesley Wellbaum

(Address)

Hanniger Mo

15.

FILED 12/3 1930J. S. Gashwiler
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 2 193017. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to Dec 10, 1930,that I last saw him alive on Aug 15, 1930, and that death occurred, on the date stated above, at 7:30 P m.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:

Brain abscess(duration) 5 yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Dehydration

(duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

at homeDID AN OPERATION PRECEDE DEATH? No DATE OF _____WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS

Clinical(Signed) J. S. Gashwiler, M. D.173 1930 (Address) Hanniger 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

Union Cem.

DATE OF BURIAL

12/3 1930

20. UNDERTAKER

Shirley Lynn Don

ADDRESS

Hanniger 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.

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