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

40366

CE OF DEATH Pike
nty Ashley
ynship
y (No. St. Ward)

Registration District No. 683
Primary Registration District No. 5911
File No.
Registered No.

L NAME Grant Blye

Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)
f 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

	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
	White	Married

ARRIED, WIDOWED, OR DIVORCED
SBAND OF
WIFE OF Unknown

OF BIRTH (MONTH, DAY AND YEAR) 1854

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ...min.
76	X	X	

PATION OF DECEASED
Trade, profession, or
icular kind of work
General nature of industry,
iness, or establishment in
ch employed (or employer)
Name of employer

HPLACE (CITY OR TOWN) Unknown
ATE OR COUNTRY) "

NAME OF FATHER "

BIRTHPLACE OF FATHER (CITY OR TOWN) "
(STATE OR COUNTRY) "

MAIDEN NAME OF MOTHER "

BIRTHPLACE OF MOTHER (CITY OR TOWN) "
(STATE OR COUNTRY)

ORMANT Frank Nester
ddress) Ashley, Mo.

ED Dec 4 1930 R. W. Hetherlin
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec4 th 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st 1929, to Dec 4th 1930, that I last saw him alive on 12-1-30, 5:30 A.M., and that death occurred, on the date stated above, at ... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Interst. Nephritis
13
Two (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chronic Myocarditis
2 (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) T. H. Wilcoxon, M. D
Dec. 4, 1930 (Address) Bowling Green 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
County Cemetery	Dec. 4 1930
20. UNDERTAKER	ADDRESS
Frank Nester	Ashley, Mo.

V. S. No. 2.

MARGIN RESERVED FOR BINDING.

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.

LOCAL REGISTRAR'S REPORT — DO NOT TEAR OUT

V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No.....) ..... St. .....

2. FULL NAME .....

(a) Residence. No..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and Sta

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	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)

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

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)

PARENTS

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....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to .....
that I last saw h..... alive on....., 19.....
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....mos.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

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WHAT TEST CONFIRMED DIAGNOSIS?.....

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