

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.

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

41667

1. PLACE OF DEATH

County Saline
Township Arrow Rock
City _____ (No. _____) St. _____ Ward _____

Registration District No. 792
Primary Registration District No. 6035

File No. _____
Registered No. _____

2. FULL NAME

(a) Residence. No. 2 Snow Rock St. Mo Ward _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 50 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

Isabell Sever

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

Feb 11 - 1854

7. AGE

YEARS

MONTHS

DAYS

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

76

9

11

8. OCCUPATION OF DECEASED

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

Farmer

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Copper Co.

(STATE OR COUNTRY)

Mo

10. NAME OF FATHER

Thomas Houley Sever

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Tenn.

12. MAIDEN NAME OF MOTHER

Middleling

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Tenn.

14.

INFORMANT

(Address)

W. Sever

Arrow Rock

15.

FILED

12-20 1930

C. L. Lawless

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Dec 12 1930

17.

I HEREBY CERTIFY, That I attended deceased from Nov 12, 1930, to Dec 11, 1930, that I last saw him alive on Dec 11, 1930, and that death occurred, on the date stated above, at 10 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Erysipelas of Right arm
became infected.

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

General debility

(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) C. L. Lawless, M. D.

Dec 13, 1930 (Address) Marshall Mo. (R)

*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

Lawless Care.

Dec 13 1930

20. UNDERTAKER

ADDRESS

W. M. Campbell Marshall

24