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

1. PLACE OF DEATH
County: Wright — Registration District No. 911 — File No. 41892
Township: Montgomery — Primary Registration District No. 6297 — Registered No.
City ..... (No. ..... St. ..... Ward)

2. FULL NAME: ~~Shear~~ Hearshead Glen Madison

(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): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feb. 23. 1926

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
4	9	18	

8. OCCUPATION OF DEECEASED
(a) Trade, profession, or particular kind of work: none
(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): Laclede Co

PARENTS
10. NAME OF FATHER: Frank Madison
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY): Unknown
12. MAIDEN NAME OF MOTHER: Nolia Cantrell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY): Mo

14. INFORMANT: Frank Madison
(Address): Manes Mo

15. FILED 12 29 1930 B. L. Johnston REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 12-11 1930

17. I HEREBY CERTIFY, That I attended deceased from 12-8 1930, to 12-11 1930 that I last saw him alive on 12-11 1930, and that death occurred, on the date stated above, at 3-P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tetanus
Cause from a nail wound
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) ..... (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) B. L. Johnston, M. D
.19 (Address) Manes 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: Manes Cemetery — DATE OF BURIAL: 12-13 1930
20. UNDERTAKER: W. V. Wade — ADDRESS: Manes Mo

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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 to

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

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 DEAT

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

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yr

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yr

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).....
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths fro
(1) MEANS AND NATURE OF INJURY, and (2) whether
HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

20. UNDERTAKER