

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.

29-1-13

23 1931

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

Do not use this space.

4548

1. PLACE OF DEATH
 7 County Bates Registration District No. 54
 Township Hudson Primary Registration District No. 5085-
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Clifford William Eddy
 (a) Residence. No. Bates County St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 30 yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

File No. _____
 Registered No. _____

PERSONAL AND STATISTICAL PARTICULARS

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

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Edith Eddy

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 31 - 1901

7. AGE 30 YEARS 1 MONTHS 14 DAYS
 IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farmer 1 1/2
 (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) Bates County

10. NAME OF FATHER William E Eddy

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Massiles, Ill

12. MAIDEN NAME OF MOTHER Margaret Phames

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Bates Co. Mo.

14. INFORMANT Margaret Eddy
 (Address) Rockville, Mo.

15. FILED Feb 18, 1931 Max A. B. Freeman
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-14-31

17. I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1931, to 2-14, 1931, that I last saw him live on Feb. 4, 1931, and that death occurred, on the date stated above, at 5:25 - P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Intestinal Hemorrhage
1 1/2 to 3 days (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) Influenza & Typhoid
few days (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 NOT AT PLACE OF DEATH
 DID AN OPERATION PRECEDE DEATH? no DATE OF 2-15-31
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) A. B. Freeman M. D.
 , 19 _____ (Address) Rockville, 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 Prarie City, Mo. DATE OF BURIAL 2/16 1931

20. UNDERTAKER Boath & Baughan Rich Hill Mo ADDRESS _____

AUG 20 1948

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

ALL INFORMATION CALLED
 FOR MUST BE WRITTEN ON
 THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Bateau Registration District No. 5-4 File No.
 Township Hudson Primary Registration District No. 5-085- Registered No.
 City (No. St. Ward)

2. FULL NAME Clifford William Eddy
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M</u>
5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Dec 31 - 1901</u>		
7. AGE YEARS <u>29</u>	MONTHS <u>1</u>	DAYS <u>13</u>
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		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/14 19 31
 17. I HEREBY CERTIFY That I attended deceased from
 to 19.....
 that I last saw h..... alive on 19..... and that
 death occurred, on the date stated above, at

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

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)....., M. D.
 , 19 (Address)

*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.

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 Apr 7 19 31 Mrs. J. B. Freeman
 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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