

MAR 24 1931

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

Do not use this space.

5074

1. PLACE OF DEATH

County Dunklin  
Township Freedom  
City..... (No. ....) St. .... Ward)

Registration District No. 284  
Primary Registration District No. 5403

File No. ....  
Registered No. 6

2. FULL NAME

Berry Griffin Holder

(a) Residence No. .... St. .... Ward. .... (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 6 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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 10 - 1849

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .... hrs. or .... min.  
82 1 15

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) (STATE OR COUNTRY) Ky.

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 Jamer Holder (Address) J Clarkton Mo

15. FILED 2-25-31 1931 J. B. Stemmes REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2 - 25 1931

17. I HEREBY CERTIFY, That I attended deceased from 2 - 18, 1931, to 2 - 25, 1931 that I last saw him alive on 2 - 24, 1931, and that death occurred, on the date stated above, at 1.00 a. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

97 Arterio Sclerosis  
(duration) 2 yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) (duration) 2 yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical  
(Signed) J. B. Stemmes, M. D.

2-25-1931 (Address) Clarkton 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 Mt Gilead Cem. DATE OF BURIAL 2-26 1931

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.

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**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 Franklin  
Township Freeborn  
City..... (No.....)..... St. .... Ward)

Registration District No. 284  
Primary Registration District No. 5403

File No.....  
Registered No. 6

**2. FULL NAME Berry Griffin Holder**

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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..... (duration)..... yrs. .... mos. .... ds.  
(b) General nature of industry, business, or establishment in which employed (or employer)..... (duration)..... yrs. .... mos. .... ds.  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

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 9-25-31 1931 J W Stearns REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 25 1931

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

**20. UNDERTAKER**

Paul Hubbard

**ADDRESS**

Clarkton

**SUPPLEMENTARY**

N. B.—Every item of information should be carefully supplied. It should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly registered. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY

