

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

Do not use this space.

5408

**1. PLACE OF DEATH**

County Jackson  
Township Kau  
City Keosauqua

Registration District No. 300  
Primary Registration District No. Trinity Lutheran Hospital

File No. 479  
Registered No. 479  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Wm Herschell Little  
(a) Residence No. Dreyer Mo. 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 Wh 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) Oct-21-1923

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
7 3 10

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer) At Home  
(c) Name of employer \_\_\_\_\_

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Maine Co. Kansas

10. NAME OF FATHER J. Th. Little

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Kans.

12. MAIDEN NAME OF MOTHER Lillie Wilson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Kans.

14. INFORMANT (Address) Froy Th. Little, Dreyer Mo.

15. FILED 71, 1931 M. M. Brown REGISTRAR  
Asst

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-1 1931

17. I HEREBY CERTIFY, That I attended deceased from 1-31 21, 1931, to 2-1-31, 1931, that I last saw him alive on 1-31-31, 1931, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

General Peritonitis from gangrene appendix  
1-31-31  
1929 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) Reperforated appendix  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED Dreyer Mo.  
IF NOT AT PLACE OF BIRTH \_\_\_\_\_

19. DATE OF OPERATION PRECEDE DEATH? yes DATE OF 1-31-31

20. WAS THERE AN AUTOPSY? no  
WHAT TEST CONFIRMED DIAGNOSIS? Operation  
(Signed) M. M. Brown M. D.

(Address) 625 Riotts Bldg  
\*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 Dreyer Mo. Sharon Cemetery DATE OF BURIAL 2-2-1931

20. UNDERTAKER Time Procedure ADDRESS City

WRITE IN INK, 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.

