MAR 25 1931

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

Do not use this space.

6165

1. PLACE OF DEATH
County Lawrence
Township Mt Vernon
City ..... (No. ..... St. ..... Ward)

Registration District No. 470
Primary Registration District No. 5633

File No. 5
Registered No. .....

2. FULL NAME Wayne Hanord
(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 Bear
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) Dec 26-1911

7. AGE 19 YEARS 2 MONTHS 9 DAYS If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer 1
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

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

PARENTS
10. NAME OF FATHER Geo Hanord
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Shellyville, Mo
12. MAIDEN NAME OF MOTHER M C Guire
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT Mo S R Mo
(Address) Mt Vernon Mo

15. FILED Mar 9, 1931 W J Fletcher REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 3, 1931

17. I HEREBY CERTIFY, That I attended deceased from Aug 29, 1930, to Feb 3, 1931 that I last saw him alive on Feb 3, 1931, and that death occurred, on the date stated above, at 6 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Pulmonary Tuberculosis

(duration) ..... yrs. 9 mos. ..... ds.

CONTRIBUTORY (SECONDARY) 2 3

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) Scott P Lehrid, M. D
, 19 (Address) Mt Vernon 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 ~~Kansas~~ Brookfield Mo
DATE OF BURIAL 3/5 1931

20. UNDERTAKER Philips & Fossett, Mt Vernon
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.