

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.

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

Do not use this space.

6202

1. PLACE OF DEATH

County Lin Registration District No. 496
Township _____ Primary Registration District No. 3025
City Boosefield (No. _____) St. _____ Ward _____

File No. _____
Registered No. 18

2. FULL NAME

George William Jefferson
(a) Residence, No. 1321 N. Central 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. 1 mos. 29 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) Dec 9 - 1930
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
1 29

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boosefield Mo

FATHER 13. NAME James Jefferson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kyrtsville Mo

MOTHER 15. MAIDEN NAME Mary E Taylor

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Quincy Mo

17. INFORMANT (ADDRESS) James Jefferson 321 N. Central Boosefield

18. BURIAL, CREMATION, OR REMOVAL PLACE Way Hill DATE 29 1931

19. UNDERTAKER (ADDRESS) Hunter Roller Boosefield Mo

20. FILED Feb 9 1931 Bessie M. Fox Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 29 1931

22. I HEREBY CERTIFY, That I attended deceased from 12/25, 1930, to 2/8, 1931
I last saw him alive on 2/8, 1931. Death is said to have occurred on the date stated above, at 3:40 P.M.
The principal cause of death and related causes of importance were as follows:

Pneumonia
Date of onset 12/25/30
Other contributory causes of importance: _____
Name of operation _____
What test confirmed diagnosis? Smear. Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) W. F. L. McCallister, M.D.
(Address) Boosefield, Mo.

100

100

**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 Linn Registration District No. 496 File No.
 Township Primary Registration District No. 3025 Registered No. 18
 City Brookfield (No.) St. Ward)

2. FULL NAME

George William Johnson
 (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) S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS II LESS than I 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)

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 4-8 1931 Bessie M. Fore REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/8 1931

17. I HEREBY CERTIFY That I attended deceased from 19....., 19....., and 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:

Pneumonia
Broncho

CONTRIBUTORY (SECONDARY)

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

ADDRESS

WHITE PLAINLY, WITH WRITING INSTRUMENTS TO BE IN FULL VIEW OF REGISTRARS. 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

1070

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