

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

Do not use this space.

20266

1. PLACE OF DEATH

County Shannon
Township Newton
City Newton (No. _____) St. _____ Ward _____

Registration District No. 1125
Primary Registration District No. 6082

File No. _____
Registered No. _____

2. FULL NAME

(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 7 4. COLOR OR RACE W 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) Mar 20-1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
64 1 21

8. Trade, profession, or particular kind of work done, as spliner, sawyer, bookkeeper, etc. Housekeeper
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) Ill

13. NAME Robert Bragg

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill

15. MAIDEN NAME Jane Morgan

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

17. INFORMANT T. B. Gratt (ADDRESS) Newton Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Gratt Cemetery DATE May-12-1931

19. UNDERTAKER none (ADDRESS) _____

20. FILED 6. 20. 1931 Camilla Trugh Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May-11-1931

22. I HEREBY CERTIFY, That I attended deceased from Jan-1-1931, to May-11-1931, last saw him alive on Apr-13-1931. Death is said to have occurred on the date stated above, at 11 P m.

The principal cause of death and related causes of importance were as follows:

Pulmonary Tuberculosis Date of onset 1-1-30

23A

Other contributory causes of importance: 23B

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ 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) John Hyde, M. D.

(Address) Newton Mo.

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.

