

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

23920

1. PLACE OF DEATH

County Schuyler
Township Prarie
City Near Queen City Mo. (No. _____)

Registration District No. 806Primary Registration District No. 6052

File No. _____

Registered No. _____

St. _____ Ward _____

2. FULL NAME William Orin Bland

(a) Residence, No. _____

St. _____

Ward _____

(If nonresident, give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 10 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)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF Mrs Wm Bland

(OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan, 2nd 1890

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

41514

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 Self

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER

James Bland

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Iowa12. MAIDEN NAME OF MOTHER Effie Hudson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Iowa14. INFORMANT Mrs William Bland(Address) Queen City Mo.15. FILED 6/17, 1931J. P. Jones

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH; DAY AND YEAR) 6-16 1931

17.

I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw him 6/11, 1931, and that death occurred, on the date stated above, at 6 A.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Suicide, from shot gun

CONTRIBUTORY (SECONDARY)

167/167

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No

DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) W. M. O'Rourke Cor. M. D., 19____ (Address) Doubling 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

DATE OF BURIAL

Queen City Cemetery 6/17 1931

20. UNDERTAKER

ADDRESS

Wm H West Queen City

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No.....
 City..... (No.....) St..... Ward.....

2. FULL NAME

(a) Residence, No..... St..... Ward.....
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX..... 4. COLOR OR RACE..... 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word).....

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.....
 (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).....

PARENTS

14. INFORMANT..... (Address).....

15. FILED..... 19..... REGISTRAR.....

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)..... 19.....

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)..... (duration)..... yrs..... mos..... da.

18. WHERE WAS DISEASE CONTRACTED..... (duration)..... yrs..... mos..... da.

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.....

20. UNDERTAKER..... ADDRESS.....