

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

Do not use this space.

32230

1. PLACE OF DEATH

County Tan Registration District No. 744
 Township Frankford Primary Registration District No. 3035
 City Richmond No. _____ St. 76 Ward _____

2. FULL NAME

Stephen Henry Andrews
 (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 Male 4. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED-OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 1st 1876

7. AGE YEARS 56 MONTHS 6 DAYS 8 If LESS than 1 day, _____ hrs. or _____ min.

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) Frankford (STATE OR COUNTRY) Kentucky

13. NAME Stephen H. Andrews

14. BIRTHPLACE (CITY OR TOWN) West Union (STATE OR COUNTRY) _____

15. MAIDEN NAME Elsie

16. BIRTHPLACE (CITY OR TOWN) West Union (STATE OR COUNTRY) _____

17. INFORMANT Hattie E. Andrews (ADDRESS) Richmond Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Sunny Slope Cem. 9-10 1931

19. UNDERTAKER A. W. Mansour (ADDRESS) Richmond Mo

20. DATE Sept 10, 1931 Registrar E. E. Day

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 9th 1931

22. I HEREBY CERTIFY That I attended deceased from _____ 19____ to _____ 19____

I last saw him alive on July 15 1931 Death is said to have occurred on the date stated above, at 12:15 p.m.

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

Apoplexy 82A
82D
General Paralysis
 Date of onset _____

Other contributory causes of importance: _____

Name of operation None Date of _____

What test confirmed diagnosis? Clinical 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? at home (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) E. E. Day M. D.

(Address) Richmond 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.

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**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 Ray
Township
City Richmond

Registration District No. 944
Primary Registration District No. 3035

File No.
Registered No. 76 St. Ward)

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 1-1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
55 6 8

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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED 11-10 1931. E. E. Jay Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/9 1931

22. I HEREBY CERTIFY, That I attended deceased from

I last saw him alive on to 19..... Death is said to have occurred on the day stated above, at m.

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

Date of onset

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

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?

If so, specify

(Signed), M. D.

(Address)

N.B. Every item of information should be carefully supplied. All deaths stated EXACTLY. PHYSICIANS should state exact statement of OCCUPATION is very important.

REGISTRARS, SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LA

SUPPLEMENTARY

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