

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

Do not use this space.

36710

1. PLACE OF DEATH

County North
Township South
City Frank City (No. _____)

Registration District No. 903
Primary Registration District No. 4545

File No. _____
Registered No. 75
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Frank City St. _____ Ward _____
(Usual place of abode)

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

Female

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

A. H. Kelso

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

Nov 15 - 1931

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>75</u>	<u>11</u>	<u>9</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House 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)

Frank Co Mo

10. NAME OF FATHER

Mr. Linney

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

Frank Co Mo

12. MAIDEN NAME OF MOTHER

Mrs. Crockett

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

Frank Co Mo

14.

INFORMANT Ed J. Jones
(Address) Frank City

15.

FILED 10-25-31 John Andrews
REGISTRAR

3

MEDICAL CERTIFICATE OF DEATH

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

Oct 24 1931

17.

I HEREBY CERTIFY, that I attended deceased from Oct 14 1931 to Oct 24 1931, that I last saw him alive on Oct 24 1931, and that death occurred, on the date stated above, at 1 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage

92 B
65 A
102

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Endocarditis Hyperthymia

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH?

DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) John Andrews, M. D.

10-25-31 (Address) Frank City

*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

Frank City Cem Oct 24 1931

20. UNDERTAKER

ADDRESS

Andrews Bros Frank City

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.

NOV 28 1931

Not to be used for
any other purpose

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Worth
Township Grant City
City Grant City (No.)

Registration District No. 903
Primary Registration District No. 4545

File No.
Registered No. 25-
St. Ward)

2. FULL NAME Francis Nelson

(a) Residence, No. St., Ward.
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>M</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Nov 15 1885</u>		
7. AGE <u>75</u>	YEARS <u>11</u>	MONTHS <u>9</u>
		DAYS <u>9</u>
		If LESS than 1 day, hrs. or min.

OCCUPATION	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 Dec 10 1931 John A. ...
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 24 1931

22. I HEREBY CERTIFY, That I attended deceased from

to, 19

I last saw h. alive on, 19. Death is said

to have occurred on the date 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)

SUPPLEMENTARY

N. B.—Every item of information should be carefully checked. 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.

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

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