

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

Do not use this space.

1. PLACE OF DEATH

County Coarter

Registration District No.

Township Jason

Primary Registration District No.

City

(No.) St.

File No. 37098

Registered No.

Ward)

2. FULL NAME

Willard Clifford Jarrett

(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

Mo

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)

Oct 4 - 1926

7. AGE

5

YEARS

MONTHS

DAY

1

23

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(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) MO

10. NAME OF FATHER

Dennis Jarrett

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) MO

12. MAIDEN NAME OF MOTHER

Pauline Julian

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) MO

14. INFORMANT

Dennis Jarrett
(Address) Ellsberry Mo.

15. FILED

..... 19

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-29 1931

17. I HEREBY CERTIFY, That I attended deceased from 11-29 1931, to 11-29 1931, that I last saw him alive on 11-29 1931 and that death occurred, on the date stated above, at 2 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tubercular Pneumonia

1074

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

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) L. G. Sheets, M. D.

, 19 (Address) Ellsberry

*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

Orchard Road Cemetery

DATE OF BURIAL

11-30 1931

20. UNDERTAKER

Had none

ADDRESS

All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S STATEMENT OF OCCUPATION is very important. DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEC 21 1931

**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 Carter Registration District No. 144
Township Jackson Primary Registration District No. 5207
City (No.) St. () Ward ()

File No. _____
Registered No. _____

2. FULL NAME

Willard clifford jarrett
(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 <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>S</u> (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.
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)				
FATHER	13. NAME			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
MOTHER	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 _____, 19 _____				

MEDICAL CERTIFICATE OF DEATH

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

Lobular Pneumonia
W. measles or Whooping

Other contributory causes of importance: 10/7 @

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

Registrar

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICAL condition should state into USE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. PARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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