

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.

39998

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

1. PLACE OF DEATH

County North
Township Wilson
City Grant City (No. _____)

Registration District No. 904
Primary Registration District No. 6215

2. FULL NAME

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

Length of residence in city or town where death occurred 20 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 15, 1850

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
81 8 4

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) Self

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Wilson Co., Mo.

10. NAME OF FATHER Henry Chicken

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

12. MAIDEN NAME OF MOTHER Elizabeth Bogue

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

14. INFORMANT Lida Chicken
(Address) Grant City, Mo.

15. FILED Mar 20, 1931 Mrs. Loiden Boyd
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 19 1931

17. I HEREBY CERTIFY, That I attended deceased from July 6, 1931, to Mar. 19, 1931, that I last saw him alive on Nov. 18, 1931, and that death occurred, on the date stated above, at 10:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Heart failure

CONTRIBUTORY (SECONDARY) 12.0 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Physician's findings

(Signed) S. J. Rose, M. D.

, 19 (Address) Grant City, 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

Grant City Cemetery 11/21 1931

20. UNDERTAKER ADDRESS

Arch C. Dunfee Grant City

