

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

Do not use this space.

41407

1. PLACE OF DEATH

County.....**Lafayette**
Township.....**Freedom**
City.....**Higginsville, Mo.**

Registration District No. **460**
Primary Registration District No. **5624a**

File No.
Registered No. **81**
St. Ward)

2. FULL NAME.....**Amos Anson**

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

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Emily E. Anson Dec 2nd**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Oct. 14th 1839**

7. AGE YEARS MONTHS. DAYS If LESS than 1 day, hrs. or min.
92 1 23

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

9. BIRTHPLACE (CITY OR TOWN).....**Lafayette Co. Mo.**
(STATE OR COUNTRY)

10. NAME OF FATHER **Peter Anson**
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Iowa.**
12. MAIDEN NAME OF MOTHER **unknown**
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **unknown**

14. INFORMANT.....**J. V. Gorman**
(Address) **Belston, Okla.**

15. FILE# **12-7-1931** **Bessie Potter**
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Dec 7** 19 **31**

17. I HEREBY CERTIFY, That I attended deceased from **Dec 3**, 19 **31** to **Dec 7**, 19 **31**
that I last saw him alive on **Dec 6**, 19 **31**, and that death occurred, on the date stated above, at **11** **A.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septic Poison
131
127R
162 (duration) yrs. mos. **6** da.

CONTRIBUTORY (SECONDARY) **Senility**
long time (duration) yrs. mos. da.

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) **H. B. Mott**, M. D.

Dec 7, 19 31 (Address) **Higginsville 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 **Cordell, Okla.** DATE OF BURIAL 19

20. UNDERTAKER **Aas & Sons** ADDRESS **Higginsville, Mo**

Every item of information should be stated EXACTLY. PHYSICIAN'S NAME AND CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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noiq u

**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 Lafayette
Township Davis
City (No.)

Registration District No. 460
Primary Registration District No. 56249

File No.
Registered No. 81
St. Ward

2. FULL NAME

Amos Amos

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

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)

MOTHER FATHER 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

19. UNDERTAKER (ADDRESS)

20. FILED 12-7-31, 19

Bessie P. Porter
Dr. W. A. Brackley
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 7 -, 1931

22. I HEREBY CERTIFY, That I attended deceased from to , 19

I last saw him 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:

unintentional poisoning Date of onset

one to chronic

3 weeks disease

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)

Every item of information should be stated EXACTLY. PHYSICIAN'S STATEMENT OF OCCUPATION is very important. 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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