

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

Do not use this space.

721

1. PLACE OF DEATH

County Greene
Township Brookline
City (No.)

Registration District No. 317
Primary Registration District No. 5441

File No.
Registered No.
St. Ward

2. FULL NAME

Albert Sidney Meadows
(a) Residence, No. 1159 W Poplar St. Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 10 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 W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 7 + 1896

7. AGE YEARS? MONTHS DAYS If LESS than 1 day, hrs. or min.
47 9 25
46 8 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Office
(b) General nature of industry, business, or establishment in which employed (or employer). 187
(c) Name of employer. 172

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO

10. NAME OF FATHER Bill Meadows

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

12. MAIDEN NAME OF MOTHER Margaret Bigh

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

14. INFORMANT Mrs. Sid Meadows
(Address) 1159 W Poplar

15. FILED 1-5-32 W. W. Shaver
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 2 1932

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
that I last saw him live on Jan 3 1932, and that death occurred, on the date stated above, at 4 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bullet wound of Head
Homicide
In physician's attendance (duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED City S-W of Springfield

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) James C. Stone M. D.

(Address) Springfield 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 East Lawn Cemetery DATE OF BURIAL Jan 5 1932

20. UNDERTAKER Floyd W. Fox ADDRESS 629 W Walnut

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.

FEB 24 1932

RECORD

