

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

Do not use this space.

19357

1. PLACE OF DEATH

46 County Hawell
Township Goldshury
City Mtn View (No. _____)

Registration District No. 383
Primary Registration District No. 5534

File No. _____
Registered No. 19 St. _____ Ward _____

2. FULL NAME

Eugene Denton

(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 Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 9 1932

7. AGE 0 YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
0 0 22

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Mtn View
(STATE OR COUNTRY) Hawell, Mo

10. NAME OF FATHER _____
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) 31
12. MAIDEN NAME OF MOTHER Irene Denton
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mtn View (STATE OR COUNTRY) Missouri

14. INFORMANT Jess Lee
(Address) Mtn View

15. FILED May 4 1932 Genevieve Ross REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from May 8, 1932, to June 2, 1932, that I last saw him alive on May 8, 1932, and that death occurred, on the date stated above, at 12:00 AM

THE CAUSE OF DEATH* WAS AS FOLLOWS:
deformed jaw bones with Hydrocephalus
157A
157D (duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (SECONDARY) 157A (duration) 1 yrs. 0 mos. 0 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) P. Ferrell M. D.
. 19 (Address) Mtn View, 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 Chapel Hill DATE OF BURIAL June 4 1932

20. UNDERTAKER None ADDRESS _____

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.

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