

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

Do not use this space.

28351

## 1. PLACE OF DEATH

County *Franklin*Registration District No. *908*Township *North Grove*Primary Registration District No. *4579*City *North Grove*

File No. \_\_\_\_\_

Registered No. *287*

St. \_\_\_\_\_ Ward \_\_\_\_\_

## 2. FULL NAME

(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. *1* 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) *Single*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 8-1908*7. AGE YEARS *24* MONTHS *00* DAYS *23* If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Electrician*

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) *Desoto, Mo.*13. NAME *Henry F. Baner*14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Desoto, Mo.*15. MAIDEN NAME *Annette Young*16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Desoto, Mo.*17. INFORMANT (ADDRESS) *Henry Baner*

18. BURIAL, CREMATION, OR REMOVAL

PLACE *Desoto, Mo.* DATE *8/3* 19*32*19. UNDERTAKER (ADDRESS) *Botten Funeral Home Desoto, Mo.*20. FILED *8/6* 19*32* *J. H. Huxford* Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Aug 1* 19*32*22. I HEREBY CERTIFY, That I attended deceased from *7/14* 19*32* to *8/1* 19*32*I last saw him alive on *8/1* 19*32* Death is saidto have occurred on the date stated above, at *8:40 a.m.*

The principal cause of death and related causes of importance were as follows:

*Injury accidental by automobile while riding motorcycle*Other contributory causes of importance: *(1) Hemiparesis*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis \_\_\_\_\_ Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide *accident* Date of injury *7/14* 19*32*Where did injury occur? *North Grove, Mo.*

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury *Motor Cycle*Nature of injury *crushed skull*

24. Was disease or injury in any way related to occupation of deceased?

If so, specify \_\_\_\_\_

(Signed) *R. A. Ryan* M. D.(Address) *North Grove, Mo.*

