

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

Do not use this space.

31800

1. PLACE OF BIRTH

26 County Bolton
3 Township Jefferson
8 City City No. _____

Registration District No. 213
Primary Registration District No. 3014

File No. 247
Registered No. _____
St. _____ Ward _____

2. FULL NAME

David Isom

(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

MEDICAL CERTIFICATE OF DEATH

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 8 - 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min.
72 7 21

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) Farming
(c) Name of employer Sullivan

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

10. NAME OF FATHER Don't know

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

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14. INFORMANT Mrs Emma Nappes
(Address) Elk Creek Mo

15. FILED 11/2/1932 Dr Bedford REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/29 1932

17. I HEREBY CERTIFY, That I attended deceased from 13th 1932 to Oct 31st 1932 that I last saw him alive on May 13th 192, and that death occurred, on the date stated above, at 3:30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitral regurgitation & Chronic Bronchitis followed by paralysis

CONTRIBUTORY (SECONDARY) J.P.A.

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? symptoms
(Signed) L.A.T. Wiley, M.D.

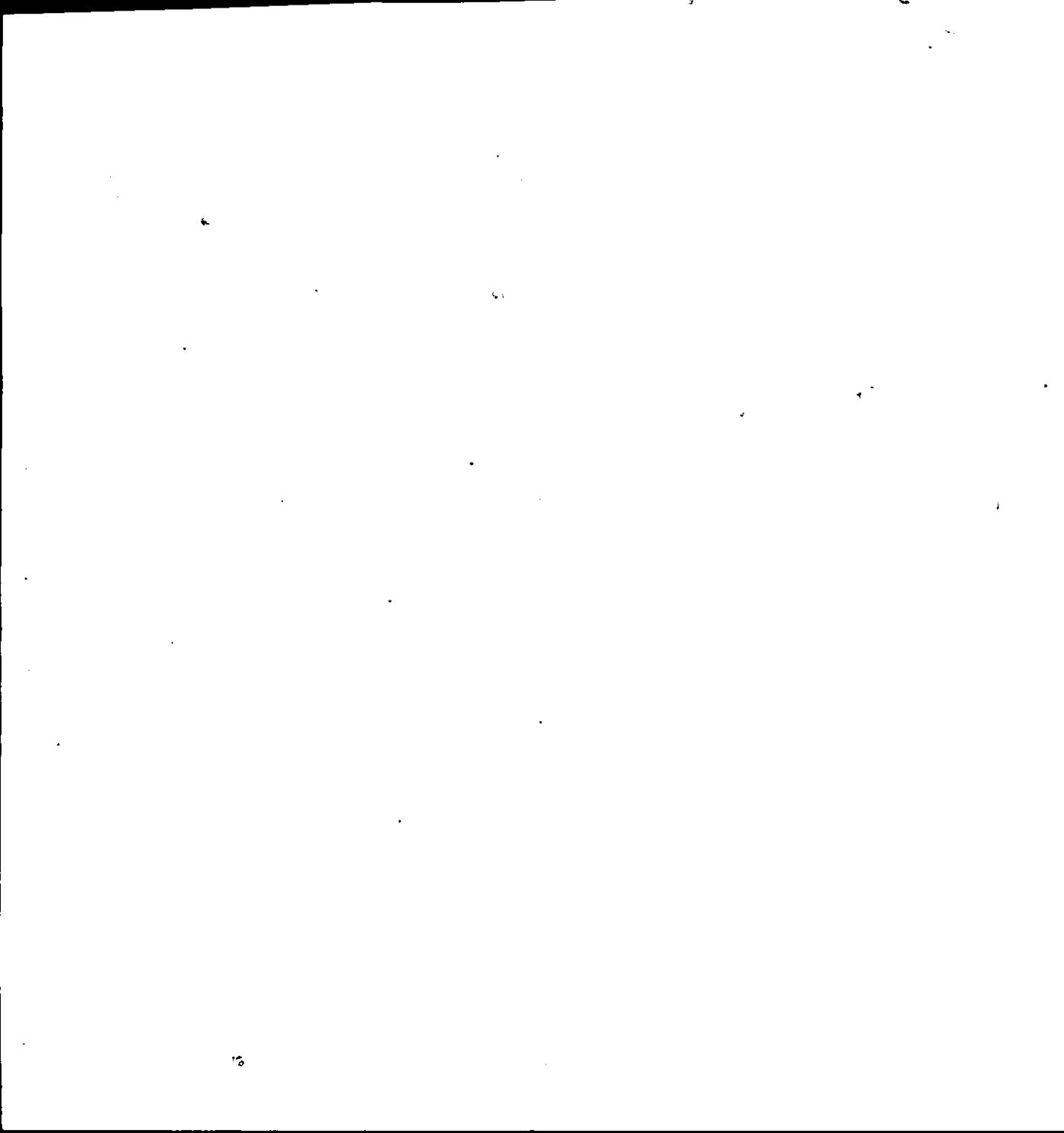
10/29, 19 (Address)

*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 Steelville DATE OF BURIAL Oct 29 32

20. UNDERTAKER Newton - Farmer ADDRESS Jeff City

NOV 23 1932



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County _____
Township _____
City Jay City (No. _____)

Registration District No. 213
Primary Registration District No. 3014

File No. _____
Registered No. 247
St. _____ Ward _____

2. FULL NAME

David Brown

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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.

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)

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 _____ 19 October 29 1932 Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 29 .1932

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

I last saw h. _____ 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:

mitral regurgitation
Chronic bronchitis
followed by paralysis
(Apoplexy)

Date of onset _____

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) J. A. J. Meyer, M. D.

(Address) J. C. M.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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