

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

Do not use this space.

32107

1. PLACE OF DEATH

County Howell

Registration District No. 387

File No. 90

Township West Plains

Primary Registration District No. 4227

Registered No. _____ St. _____ Ward _____

City West Plains (No. _____)

2. FULL NAME Rolla Eldon Mayhew

(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 29 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** Single (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 26, 1903

7. AGE YEARS 29 MONTHS 2 DAYS 3 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. General Contractor and repair

10. Date deceased last worked at this occupation (month and year) Oct 20, 1932 **11. Total time (years) spent in this occupation** 32

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 31

13. NAME Rolla Mayhew

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N.Y. State

15. MAIDEN NAME Laura Roberts

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Howell Co., Mo.

17. INFORMANT (ADDRESS) Mrs. Ed. Coate West Plains, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Lawn DATE Oct 31 1932

19. UNDERTAKER (ADDRESS) Hal Thomburg West Plains, Mo.

20. FILED 11-3-1937 O.P. Kemmich Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/29/32, 1932

22. I HEREBY CERTIFY, That I attended deceased from 10/20/32, 1932, to 10/29/32, 1932.

I last saw him alive on 10/29/32, 1932. Death is said to 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:

Uraemia, Acute, with suppression of urine, due to

Date of onset 10/22/32

Other contributory causes of importance: Gastro-enteritis, from Ptomaine poisoning, 10/20/32.

Name of operation None Date of _____
What test confirmed diagnosis? Clinical Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 1932

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? NO
If so, specify _____

(Signed) Arthur Lewis, M. D.
(Address) West Plains, Missouri

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**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

32-107

1. PLACE OF DEATH

County Howell
Township West Plains
City West Plains

Registration District No. 384
Primary Registration District No. 4227

File No. _____
Registered No. _____
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. 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 (W the word)

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 11-3- 1932 J. P. A. Heunich Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/29, 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:

Uremia, acute with suppression of urine
Don't know cause 10/29 1932

Other contributory causes of importance:

Gastric enteritis from ptomaine poisoning
Don't know cause

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) _____

SUPPLEMENTARY

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.

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

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