

Dr. George  
**MISSOURI STATE BOARD OF HEALTH**  
**BUREAU OF VITAL STATISTICS**  
**CERTIFICATE OF DEATH**

Do not use this space.

39342

**1. PLACE OF DEATH**

County Greene  
 Township  
 City Stratford R. 703

Registration District No. 444  
 Primary Registration District No. 5447B

File No. L3  
 Registered No. L3  
 St. \_\_\_\_\_ Ward)

**2. FULL NAME**

(a) Residence, No. Stratford R. 703 St. \_\_\_\_\_ Ward.

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**

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) 3-8-1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
68 9 18

OCCUPATION 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) Alabama

FATHER 13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Mrs. Mrs. C. ...

18. BURIAL, CREMATION, OR REMOVAL PLACE Springfield DATE Dec 30, 1933

19. UNDERTAKER (ADDRESS) J. Floyd ...

20. FILED 1-1 19 33 A. B. Grier Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-26, 1933

22. I HEREBY CERTIFY, That I attended deceased from

1933 to 1933  
 I last saw him undead on 12-26, 1933 Death is said

to have occurred on the date stated above, at 4 P. m.

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

Date of onset  
Asphyxiation from  
drooping wall  
179M  
 Other contributory causes of importance  
1779  
(5)

23. Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? Autopsy Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 1933

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) Oliver A. George - coroner, M. D.

(Address) Springfield Mo

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.

JAN 23 1934

*A. T. Moore*  
*St. Louis*

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

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Greene

Registration District No. 944

File No. 39342

Township Strofford

Primary Registration District No. 5447B

Registered No. 63

City Strofford (No. \_\_\_\_\_)

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

2. FULL NAME

Sam Gualle

(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 (write the word) Widowed

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.  
68 9 18

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 1-1 1933 Asst. Registrar  
Clyde Anderson  
Present Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-26-32

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:

Gas poisoning from wood alcohol

Date of onset

Other contributory causes of importance:

Was in a drunken condition when he drank the wood alcohol.

Name of operation none Date of \_\_\_\_\_

What test confirmed diagnosis? Autopsy Was there an autopsy? Yes

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

Accident, suicide, or homicide Accident Date of injury 12/26, 1932

Where did injury occur? Strofford, Greene Co., Mo.

(Specify city or town, county, and State)

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

Home

Manner of injury Drank wood alcohol

Nature of injury When in drunken condition

24. Was disease or injury in any way related to occupation of deceased? No.

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

(Signed) Chas. A. George, M.D.

(Address) Springfield

SUPPLEMENTARY

S-39342