MAR 2

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

2476

247

1. PLACE OF DEATH
2. County New Madrid — Registration District No. 55 — File No. 10
2. Township — Primary Registration District No. 4033 — Registered No. 1023
6. City Gideon (No. ..... St. ..... Ward)

2. FULL NAME Frank Calvin Mims

(a) Residence. No. Tallapassa St., ... Ward. (If nonresident, give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
male	white	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 28 1891

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	41	6	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farm 23A 1078
(b) General nature of industry, business, or establishment in which employed (or employer) Walsforsell
(c) Name of employer

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

PARENTS

10. NAME OF FATHER Charles Mims
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Murry
(STATE OR COUNTRY) Ky
12. MAIDEN NAME OF MOTHER Millie Ann Stratton
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Maley
(STATE OR COUNTRY) Mo

14. INFORMANT Henry Mims
(Address)

15. FILED Feb 10 1933 M V Mummer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 17 1933

17. I HEREBY CERTIFY, That I attended deceased from Jan 5, 1933, to Jan 19, 1933 that I last saw him alive on Jan 5, 1933, and that death occurred, on the date stated above, at 1 45 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Pneumonia Bronchial and Chronic Tuberculosis with abscess — 23 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chronic Tuberculosis Was in U. S. Tulsa (duration) 10 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Cook about 4 years ago and seven years ago
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Graydon Carlstrom, M.D.
, 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	DATE OF BURIAL
Mt Gilead	1-18 1933
20. UNDERTAKER	ADDRESS
Wood None	

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1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No.....

City..... (No....., ...St. .....

2. FULL NAME.....

(a) Residence. No.....St., ...Ward. .....
(Usual place of abode) (If nonresident, give city or town a

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	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)

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

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).....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT.....
(Address)

15. FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased fro
....., 19....., to.....
that I last saw h..... alive on....., 1
death occurred, on the date stated above, at.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) .....yrs.....

CONTRIBUTORY.....
(SECONDARY)

..... (duration) .....yrs.....

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).....

, 19 (Address)

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE

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