

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

Do not use this space.

5064

1. PLACE OF DEATH

County Christian Registration District No. 184
 Township Finding Primary Registration District No. 5255
 City Deerfield (No. _____) St. _____ Ward _____

File No. _____

Registered No. 6

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 (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1857

7. AGE YEARS 79 MONTHS Don't know DAYS Don't know If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Minister Grocerman

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) Texas

13. NAME Don't know

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

15. MAIDEN NAME Don't know

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

17. INFORMANT Laura Holbert (ADDRESS) Deerfield Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Deerfield DATE 2/26 1933

19. UNDERTAKER B. C. Klepper (ADDRESS) Deerfield Mo.

20. FILED March 2 1933 Ruth Harrison Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 25 1933

22. I HEREBY CERTIFY, That I attended deceased from Feb. 17 1933, to Feb 25 1933

I last saw him alive on Feb. 25 1933. Death is said to have occurred on the date stated above, at 40 m.

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

Impaction of Gall Bladder with inflammation of liver
1250
125B
 Other contributory causes of importance: _____

Date of onset _____

Name of operation None 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 _____, 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

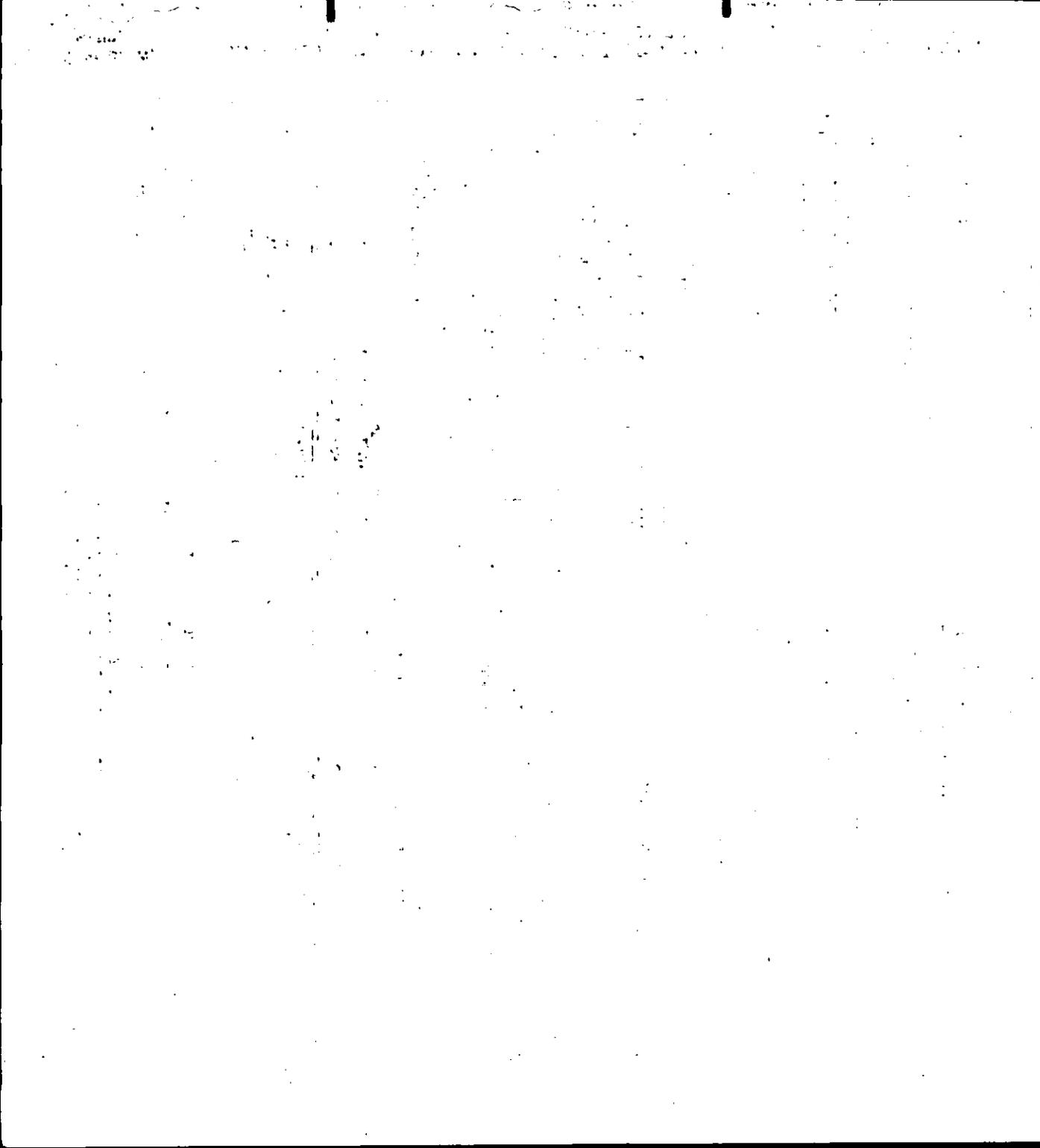
If so, specify _____

(Signed) J. H. Wade _____, M. D.

(Address) Deerfield 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.

WRITE CLEARLY WITH UNFADING INK—THIS IS A PERMANENT RECORD



from the death certificate.

Name: Rev. Dr. J. Robert Christian
Who died at Lyons (City) Christian (County) on Feb. 25 - 1913 (Date)

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex _____ Color or race _____ Single, married, widowed or divorced: _____

Date of birth _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or Country) _____

Birthplace of father (State or Country) _____

Birthplace of mother (State or Country) _____

Principal cause of death: Infection of Gall bladder inflammation of liver

Other contributory causes of importance N. K. Stone that knew of

Name of operation No operation Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? No

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 None

Nature of injury _____

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

If so, specify _____

Name of physician J. W. Wade

Address of physician Lyons Mo

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the inclosed official envelope which requires no postage.

Very truly yours,

S-5064