

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

Do not use this space.

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1. PLACE OF DEATH
 72 County New Madrid Registration District No. 274
 Township Lewis Primary Registration District No. 6241
 City _____ (No) _____ St. _____ Ward _____

2. FULL NAME Jared Edwin Cecil
 (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

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 (Usual place of abode)
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 19 - 1932
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
9 6
 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) New Madrid Co
 (STATE OR COUNTRY) Mo.

FATHER 13. NAME J. W. Cecil
 14. BIRTHPLACE (CITY OR TOWN) Perry Co
 (STATE OR COUNTRY) Mo.

MOTHER 15. MAIDEN NAME Mary Glass
 16. BIRTHPLACE (CITY OR TOWN) Lake Co
 (STATE OR COUNTRY) Mo.

17. INFORMANT J. W. Cecil
 (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL
 PLACE New Madrid Co DATE 2-25 1933

19. UNDERTAKER Hill Bros
 (ADDRESS) Libbourn Mo.

20. FILED Feb 27, 1933 E. E. Jones
 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 _____, 19____, to _____, 19____
 I last saw him alive on Feb 24, 1933. Death is said to have occurred on the date stated above, at 5:30 am.

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

Leukemia Date of onset _____
107A
 Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

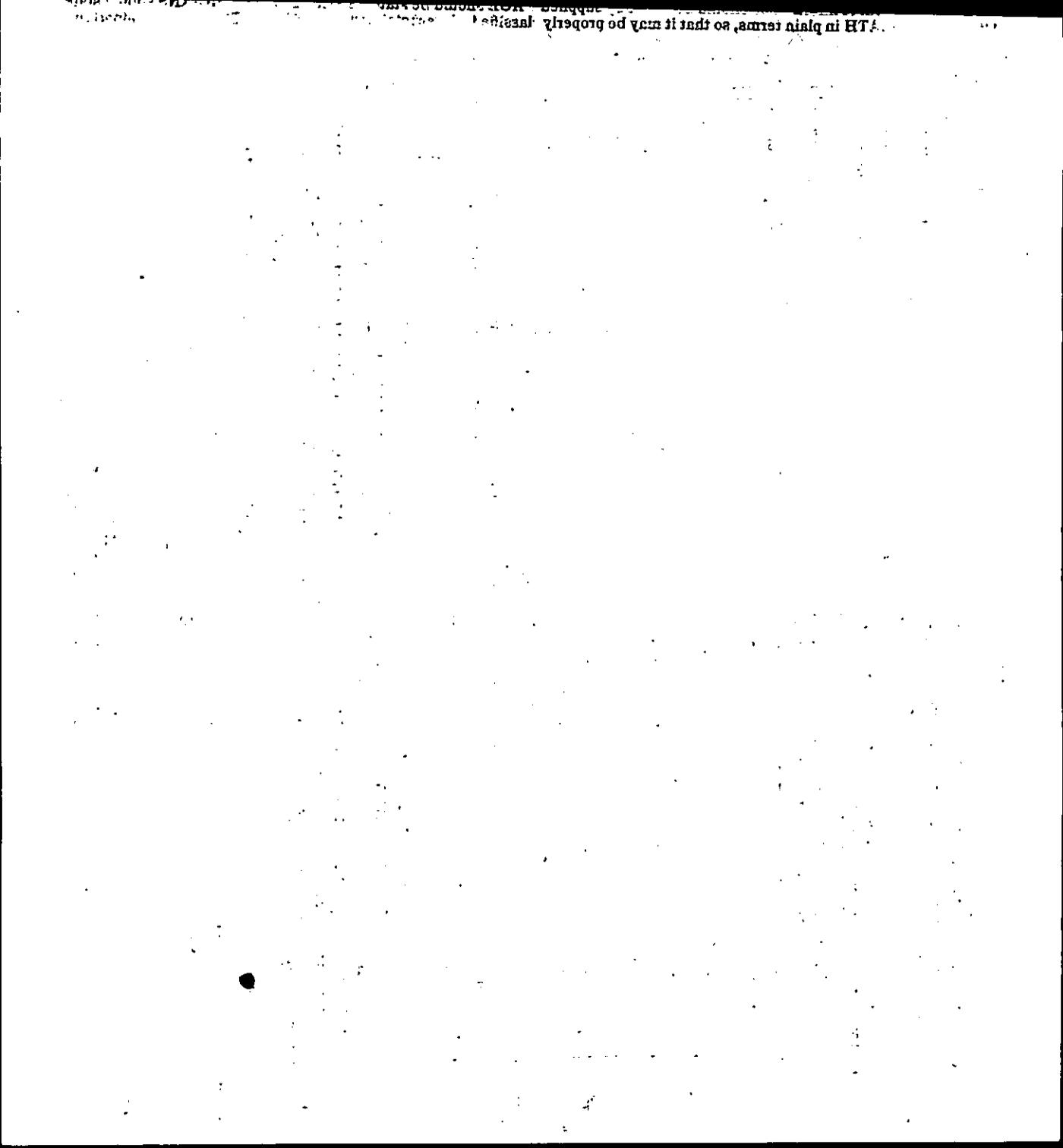
23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____

(Signed) J. W. Cecil, M. D.
 (Address) Libbourn Mo.

Exact statement of OCCUPATION is very important.



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County New Madrid Registration District No. 274 File No. _____
 Township Linn Primary Registration District No. 6261 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Jared Colman Cecil
 (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) W

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 19 - 1932

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
9 6

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__ E. E. Jones
 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 _____ to _____, 19__

I last saw h. _____ alive on _____, 19__ Death is said to have occurred on the _____ stated above, at _____ m.

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

Spinal pneumonia Date of onset _____
did not follow whooping cough nor measles

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) _____, M. D.

(Address) _____

SUPPLEMENTARY

1070

CAUSE OF DEATH in plain terms, so 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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