

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

Do not use this space.

8811

1. PLACE OF DEATH:

County Pike
Township Calumet
City Clarksville (No.)

Registration District No. 685
Primary Registration District No. 44.69

File No. 24
Registered No. 5
St. Ward)

2. FULL NAME Frank Currie

(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 Male **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** Widower (write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 9 - 1849

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. min.
	<u>83</u>	<u>6</u>	<u>18</u>	

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

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 127 1/2

10. Date deceased last worked at this occupation (month and year) 167

11. Total time (years) spent in this occupation 127 1/2

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ed. Co. Ky

MOTHER FATHER

13. NAME John Currie

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

15. MAIDEN NAME Christine McDonald

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

17. INFORMANT Martha Currie
(ADDRESS) Clarksville, Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Clarksville DATE 3-28 1933

19. UNDERTAKER H. Brown
(ADDRESS) Clarksville

20. FILED 2-28 1933 H. H. Bradley
Registrar

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 27 1933

22. I HEREBY CERTIFY, That I attended deceased from Nov 1 1932 to Feb 27 1933
I last saw him alive on Feb 27 1933. Death is said to have occurred on the date stated above, at 2:30 p. m.
The principal cause of death and related causes of importance were as follows:
Obstruction of bowels.
Inflammation of eye.
Date of onset

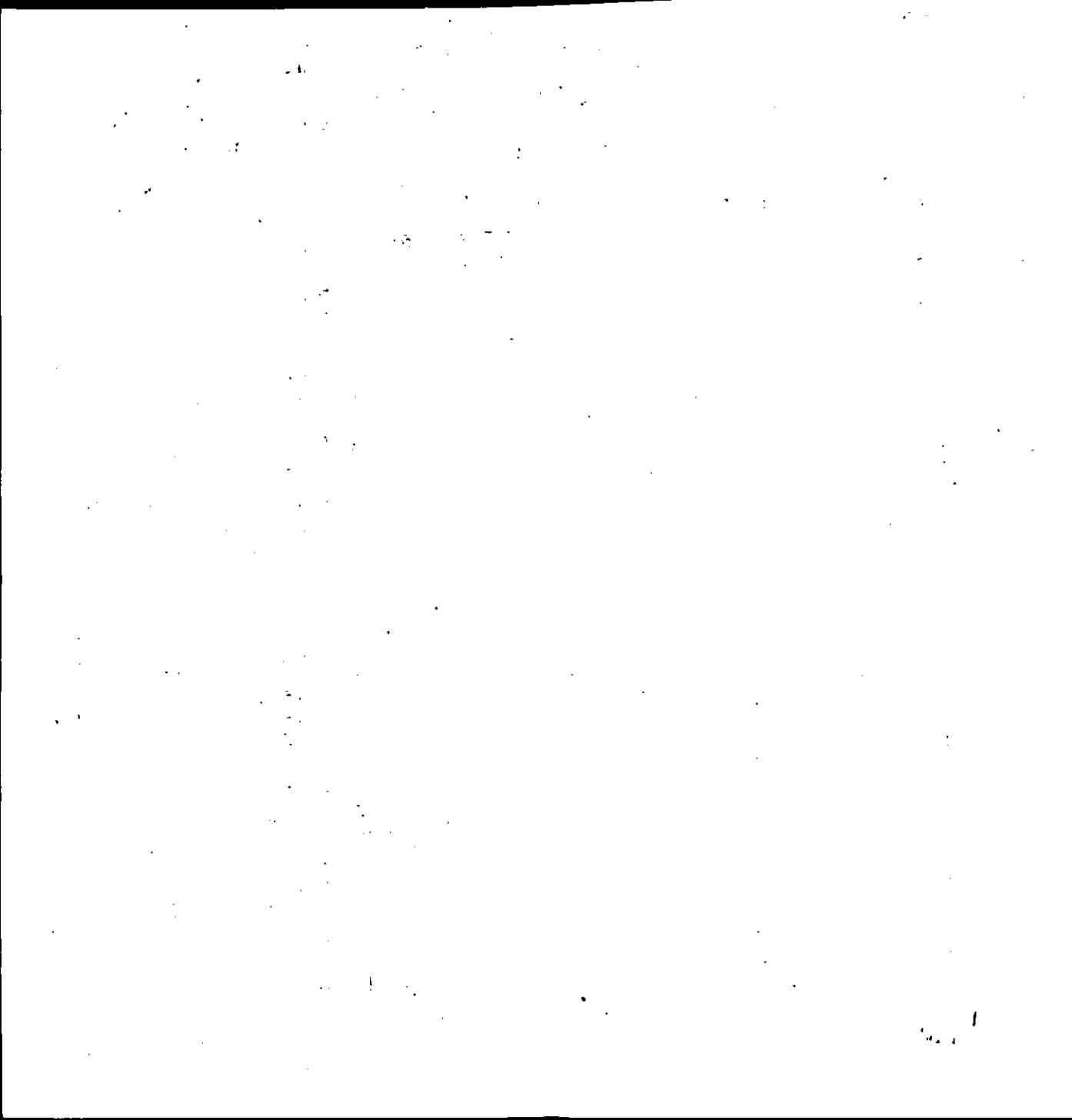
Other contributory causes of importance:

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 of heart (Signed) Clarksville, Mo, M. D.
(Address) Clarksville, Mo



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Boone Registration District No. 1085 File No. 24
 Township 1st Primary Registration District No. 4409 Registered No. 15
 City Clarksville (No. _____) St. _____ Ward _____

2. FULL NAME Frank Currie

(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 Mrs. St. Currie

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
83 6 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 _____ 19____ H. H. Treanbey Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 27 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: _____ Date of onset _____

Obstruction of bowels
Intussusception of sigmoid
Don't know what caused it.

Other contributory causes of importance: _____

Name of operation 221B 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

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

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