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

Do not use this space.

12097

1. PLACE OF DEATH
County: Texas
Township: Piney
City: ..... (No. ....., ... St. ..... Ward)

Registration District No. 863
Primary Registration District No. 6137

File No. .....
Registered No. .....

2. FULL NAME: Bennie M. Meador

(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: Samantha Keeney Meador

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

7. AGE: YEARS 27 | MONTHS 3 | DAYS 5 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Electrician
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): Houston Mo

FATHER
13. NAME: Ben C Meador
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Va

MOTHER
15. MAIDEN NAME: Julia A. Geltys
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo

17. INFORMANT (ADDRESS): Smith Ferguson, Licking, Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Houston, Mo DATE: May 10, 1933

19. UNDERTAKER (ADDRESS): Smith Ferguson, Licking, Mo

20. FILED: May 9, 1933 W. O. Herron, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): May 9, 1933

22. I HEREBY CERTIFY, That I attended deceased from May 8, 1933, to May 9, 1933
I last saw h. alive on May 8, 1933. Death is said to have occurred on the date stated above, at 4 H m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
General Tuberculosis	
(Lungs - Bowels - Kidneys -)	

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) W. O. Herron, M. D.
(Address) Houston, Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 Texas — Registration District No. 863 — File No.

Township Piney — Primary Registration District No. 6137 — Registered No.

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Bennie M. Meador

(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): M

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 4 - 1906

7. AGE — YEARS: 27 — MONTHS: 3 — DAYS: 5 — If LESS than 1 day, ... hrs. or ..... min.

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) .....

FATHER

13. NAME .....

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

MOTHER

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 May 10 19.... N. L. Herron Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 9, 1933

22. I HEREBY CERTIFY, That I attended deceased from ....., 19...., 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:

	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 .....

(Signed) ....., M. D.

(Address) .....

SUPPLEMENTARY

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.

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