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

JUN 20 1933

1. PLACE OF DEATH
County Boone — Registration District No. 74 — File No. 18906
Township — Primary Registration District No. 4042 — Registered No. 7
City Hallsville (No. ..... St. ..... Ward)

2. FULL NAME John Lee Pemberton
(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 (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Sahala Frances Pemberton

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Sep 30 - 1855

7. AGE: Years 77 — Months 8 — Days 5 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Mail Carrier
(b) General nature of industry, business, or establishment in which employed (or employer): Carried mail from train to P.O.
(c) Name of employer: U.S.

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY): Mo.

PARENTS
10. NAME OF FATHER: Tilford Pemberton
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Washington
(STATE OR COUNTRY): Ky.
12. MAIDEN NAME OF MOTHER: Sarah Lee
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY): Kentucky

14. INFORMANT: Mrs. Frances Pemberton
(Address): Hallsville Mo

15. FILED 6-6-1933 Mrs. F. L. Fauett
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): June 5 1933

17. I HEREBY CERTIFY, That I attended deceased from May 5th, 1933, to June 5, 1933 that I last saw him alive on June 4, 1933, and that death occurred, on the date stated above, at 10.30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
~~Gastritis~~
Cirrhosis of Liver
124B
118C (duration) unknown yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Gastritis - Chronic
(duration) 1 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 124B
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) C. B. Lawrence, M.D.
June 5, 1933 (Address) Hallsville Mo

*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: Grandview Cemetery — DATE OF BURIAL: 6-6-1933

20. UNDERTAKER: G. L. Shock - Hallsville Mo. — ADDRESS

V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

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CERTIFICATE OF DEATH

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

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

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

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.

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(a) Trade, profession, or particular kind of work .....

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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) - 19

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death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos. .....ds.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos. .....ds.

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IF NOT AT PLACE OF DEATH?.....

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WHAT TEST CONFIRMED DIAGNOSIS?.....

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

, 19 (Address)

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