

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

Do not use this space.

**31969**

**1. PLACE OF DEATH**

County Jasper  
Township Deliver  
City (No. ....) St. .... Ward

Registration District No. 959  
Primary Registration District No. 6130

File No. 13  
Registered No. ....

**2. FULL NAME**

@ @ Ethrige  
(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**

2. SEX male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 10 1851

7. AGE YEARS 82 MONTHS 2 DAYS 28 IF LESS than 1 day, .... hrs. or .... min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work farmer  
(b) General nature of industry, business, or establishment in which employed (or employer) .....  
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Don't know  
(STATE OR COUNTRY) McDonald Co Mo

PARENTS

10. NAME OF FATHER X  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know  
(STATE OR COUNTRY) .....  
12. MAIDEN NAME OF MOTHER X  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) X  
(STATE OR COUNTRY) .....

14. INFORMANT Lee Enders  
(Address) Deliver Mo

15. FILE 9/9 1993 John H Baxter REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 8 1993

17. I HEREBY CERTIFY, That I attended deceased from Sept 5 1993 to Sept 7 1993 that I last saw him alive on Sept 5 1993, and that death occurred, on the date stated above, at 4 o'clock.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Symptomatic of Prostate Gland and Bladder  
137  
135B (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 137 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED at place of death  
IF NOT AT PLACE OF DEATH, .....  
DID AN OPERATION PRECEDE DEATH, ..... DATE OF .....

WAS THERE AN AUTOPSY? .....  
WHAT TEST CONFIRMED DIAGNOSIS? .....  
(Signed) Dr J L ... M. D.  
, 19 (Address) Omaha ark

\*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 Omaha ark DATE OF BURIAL Sept 9 1993

20. UNDERTAKER None ADDRESS .....

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

M. 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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