

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.

NOV 10 1933

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

Do not use this space.

37546

1. PLACE OF DEATHCounty Adair Co.Registration District No. 714File No. 2Township UnionPrimary Registration District No. 43Registered No. 19City Bloodland(No. 5993)

St. _____ Ward _____

2. FULL NAMELeathy Elizabeth J. R.

(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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Infant</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Infant</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>10/17/33</u>		
7. AGE YEARS	MONTHS	DAYS
		If LESS than 1 day, _____ hrs. or _____ min.
		<u>19</u>

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)(STATE OR COUNTRY) Adair Co. Mo.**PARENTS**10. NAME OF FATHER Wm. L. J. R.

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo.12. MAIDEN NAME OF MOTHER Leathy Horner

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo.**14.**INFORMANT Wm. L. J. R.(Address) Bloodland**15.**FILED 11-8-1933 S. G. Koonce

REGISTRAR

MEDICAL CERTIFICATE OF DEATH16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/5 193317. I HEREBY CERTIFY, That I attended deceased from 11/5, 1933, to 11/5, 1933that I last saw him alive on 11/5, 1933, and that death occurred, on the date stated above, at 10:30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Concussion

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

CONTRIBUTORY Amnesia (7.9m)

(SECONDARY)

Unknown (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTEDIF NOT AT PLACE OF DEATH ☒

9 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? ☒WHAT TEST CONFIRMED DIAGNOSIS Polio(Signed) C. A. Talbot, M. D.10/6, 1933 (Address) Wraymuller

*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**DATE OF BURIAL**Bloodland Cemetery 11-8-1933**23. UNDERTAKER****ADDRESS**U. S. Kinner Bloodland

