

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

Do not use this space.

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1. PLACE OF DEATH *Camden*
 County *Benton* Registration District No. *118*
 Township *Adair* Primary Registration District No. *5769*
 City (No.) St. Ward)

2. FULL NAME *Deville Flippin*
 (a) Residence. No. *Edwards* *ms.* 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 *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*curie* the word) *Widowed*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Bessie Flippin*
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug 28 - 1895*
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
39 5 28

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *Mining*
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Nashville*
 (STATE OR COUNTRY) *Benton Co. Mo*

10. NAME OF FATHER *Unknown (Bastard child)*
 11. BIRTHPLACE OF FATHER (CITY OR TOWN)
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER *Flippin*
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Nashville*
 (STATE OR COUNTRY) *Benton Co. MO?*

14. INFORMANT *Hinda Flippin*
 (Address) *Edwards Mo.*

15. FILED *1-29, 1934* *W.S. Windsor*
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *1-25-1934*
 I HEREBY CERTIFY, That I attended deceased from *Oct.* 19*31*, to *1-25-* 19*34*, that I last saw him alive on *Oct.* 19*33*, and that death occurred, on the date stated above, at *5 P.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis
23A (duration) *23A* yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH
 DID AN OPERATION PRECEDE DEATH? DATE OF
 WAS THERE AN AUTOPSY?
 WHAT TEST CONFIRMED DIAGNOSIS *Specimen* M. D.
 (Signed) *Wasson* M. D.
 , 19 (Address) *Nashville 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 *Clinch Springs* DATE OF BURIAL *1-27-1934*
 20. UNDERTAKER *Roy Sabrown* ADDRESS

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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