

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

Do not use this space.

863

1. PLACE OF DEATH

County Hogewald
Township 2nd Center
City (No. _____) _____

Registration District No. 320
Primary Registration District No. 5443

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Wilson Alvis Daniel

(a) Residence. No. Cash Grove mo. R.D. 3 St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 50 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 Florence Daniel

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

7. AGE 72 YEARS MONTHS _____ DAYS _____ 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)

(STATE OR COUNTRY) North Carolina

10. NAME OF FATHER Alvis Daniel

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) North Carolina

12. MAIDEN NAME OF MOTHER Paula Brown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) North Carolina

14.

INFORMANT Jim Daniel
(Address) Cash Grove mo.

15.

FILED 1/26, 1934 Lucretia Hoyal REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 25 1934

17. I HEREBY CERTIFY, That I attended deceased from Jan 16, 1934, to Jan 25, 1934, that I last saw him alive on Jan 24, 1934, and that death occurred, on the date stated above, at 1:30 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic interstitial nephritis
Prostatic obstruction

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) Charles H. Staffor, M. D.

1-25-1934 (Address) Cash Grove 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

DATE OF BURIAL

Johns Chapel

1-26-1934

20. UNDERTAKER

ADDRESS

Brim Undertaking Co

Walnut

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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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

863-

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Wilson Alvis Daniel
Who died at _____ on Jan. 25 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____
Sex _____ Color or race _____ Single, married, widowed or divorced: _____

Date of birth Dec. 12 - 1862 Age: (Years 71 Months 1 Days 13)

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____
Birthplace (State or country) _____
Birthplace of father (State or country) _____
Birthplace of mother (State or country) _____
Principal cause of death: _____

Other contributory causes of importance _____
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
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 _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician _____

Address of physician _____
Signature of Registrar (Luce E. Royal) Date filed _____

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

Reg. Dist. No. 320

Primary Reg. Dist. No. 5443

E. T. McGaugh
Special Agent. *m.p.*

S-863

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