

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state

FEB 8 1935

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

Do not use this space.
2107 ²⁵ J
File No. _____
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH

County Pemiscot
Township _____
City Steele Mo. (No. _____)

Registration District No. 655
Primary Registration District No. 4397

2. FULL NAME

J. C. White

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE C 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-8-1919

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 16 - 27

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. L

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Drew

13. NAME Turn White

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Drew, Miss

15. MAIDEN NAME Ola Williams

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Drew, Miss

17. INFORMANT (ADDRESS) John Higgins

18. BURIAL, CREMATION, OR REMOVAL PLACE Dallas, Ark DATE 1-4-35 1935

19. UNDERTAKER (ADDRESS) Greenwood Co

20. FILED 7/1 1935 Max J. Hines Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-4-35 1935

22. I HEREBY CERTIFY, That I attended deceased from 1-23, 1935, to _____, 19____.

I last saw h.l.m. alive on 1-3, 1935. Death is said to have occurred on the date stated above, at D. P. m.

The principal cause of death and related causes of importance were as follows:

meningitis (Pocahontas Street) Date of onset 79A

Other contributory causes of importance: key

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. 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 _____

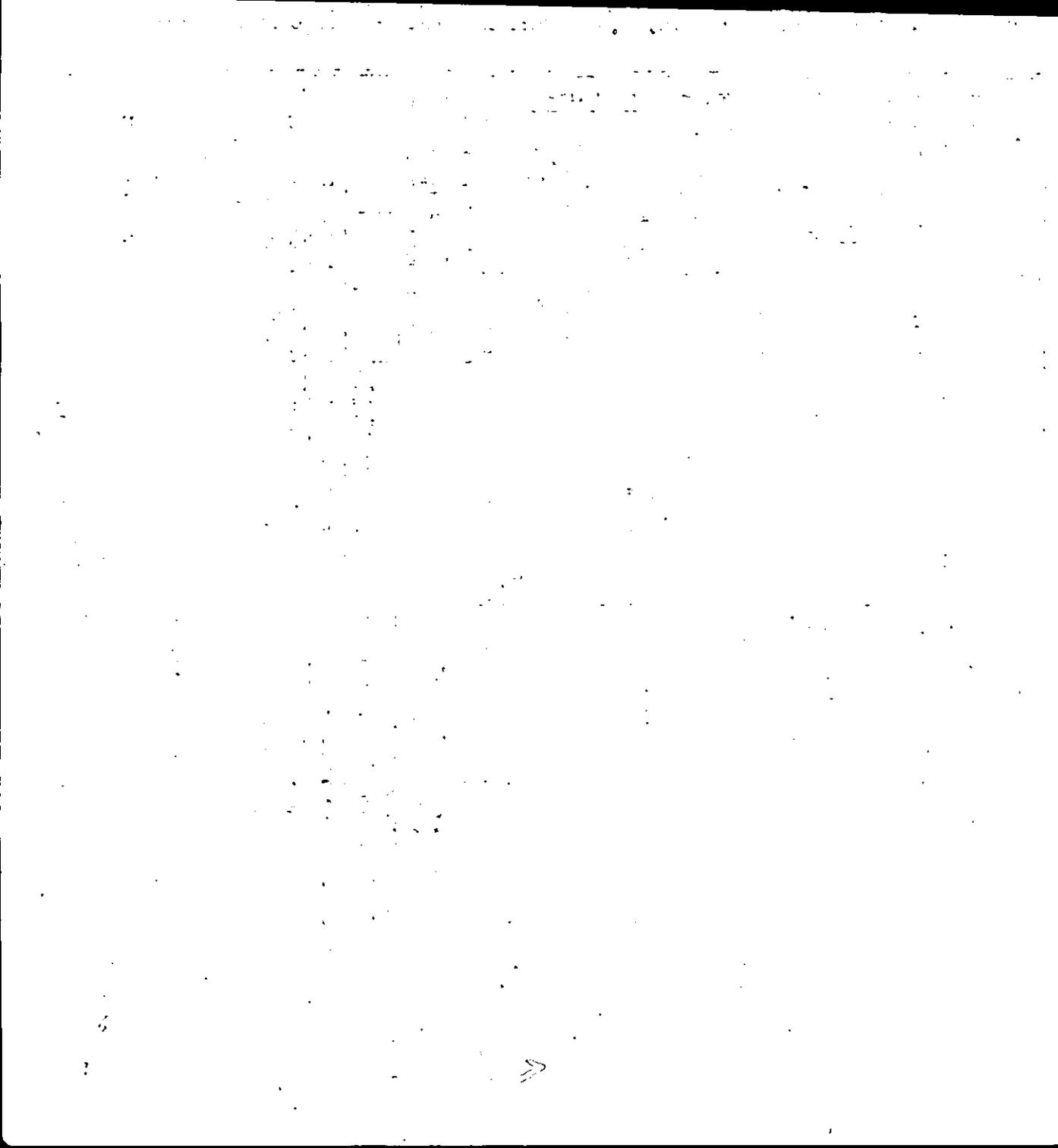
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) R. Chapman, M. D.

(Address) Steele, Mo.



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

Do not use this space.

2101-F

1. PLACE OF DEATH

County Deming
Township Steele
City Steele (No. _____)

Registration District No. 655
Primary Registration District No. 4392

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

2. FULL NAME

G. C. White

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE B 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write this word) S

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 8-1919

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ yrs. or _____ mos. or _____ ds.
16 27

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER
13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER
15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL
PLACE _____ DATE _____ 19 _____

19. UNDERTAKER (ADDRESS) _____

20. FILED 2/1 1934 May 4 Kelly Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 4 (1934)

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

(Possible Strept.)
Meningitis
Spinal
Date of onset 16

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. 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 _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) J. B. Chapman, M. D.

(Address) Steele, Mo.

