

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.

# MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

### CERTIFICATE OF DEATH

Do not use this space.

## 1. PLACE OF DEATH

County Superior  
 Township Saline  
 City Geo. W. Dawson (No. 290)

Registration District No. 290  
 Primary Registration District No. 5408

File No. 4488  
 Registered No. 30  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

## 2. FULL NAME

(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>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Nov. 22, 1862</u>		
7. AGE	YEARS <u>71</u>	MONTHS <u>2</u>
	DAYS <u>26</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Farming</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>Farming</u>	
	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) <u>Ky</u>		
FATHER	13. NAME <u>Don't Know</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Don't Know</u>	
MOTHER	15. MAIDEN NAME <u>Don't Know</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Don't Know</u>	
17. INFORMANT <u>Mr. J. S. D. Good</u> (ADDRESS) <u>Don't Know</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Reburied</u> DATE <u>Feb 19, 1934</u>		
19. UNDERTAKER <u>W. H. Burdick</u> (ADDRESS) <u>Don't Know</u>		
20. FILED <u>3-25-34</u> <u>1934</u> <u>Don't Know</u> Registrar		

## MEDICAL CERTIFICATE OF DEATH

2. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 18, 1934

22. I HEREBY CERTIFY, That I attended deceased from Jan 6, 1924, to Feb 18, 1934.  
 Last saw him alive on Feb 18, 1934. Death is said to have occurred on the date stated above, at 10:00 a.m.

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

Myocarditis  
Chronic Hypertension

Date of onset \_\_\_\_\_

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) Robert G. M. M. M., M. D.  
 (Address) Don't Know

