

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

Do not use this space.

7538

1. PLACE OF DEATH
106 County Fernon Registration District No. 873
Township Deerfield Primary Registration District No. 5
City Deerfield (No. _____) St. _____ Ward _____

2. FULL NAME William David Daniels
(a) Residence. No. Rt 1 - Deerfield Mo Ward. _____
(Usual place of abode)
Length of residence in city or town where death occurred 1 1/2 yrs. _____ mos. _____ ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 11 - 1934

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

17. I HEREBY CERTIFY, That I attended deceased from 9 of Feb, 1934 to Feb 11, 1934 that I last saw him alive on Feb 10, 1934 and that death occurred, on the date stated above, at _____ m.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Ureaemic Poisoning
Repletes

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
35 - 4 - 15

CONTRIBUTORY (SECONDARY) Repletes
(duration) _____ yrs. _____ mos. _____ ds.

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 Self

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____

9. BIRTHPLACE (CITY OR TOWN) Springfield Mo
(STATE OR COUNTRY)

DID AN OPERATION PRECEDE DEATH _____ DATE OF _____

10. NAME OF FATHER Wm Daniels

WAS THERE AN AUTOPSY _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Cambridge Vt
(STATE OR COUNTRY)

WHAT TEST CONFIRMED DIAGNOSIS Urinalysis
(Signed) W. B. Brewer M. D.
, 19 _____ (Address) Deerfield Mo

12. MAIDEN NAME OF MOTHER Judy Hawkins

*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.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Champaign Ill.
(STATE OR COUNTRY)

14. INFORMANT Mrs Wm D Daniels
(Address) Rt 1 - Deerfield Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Deerfield Mo DATE OF BURIAL 2-13-34

15. Feb 27 1934 Mrs W B Brewer
REGISTRAR

20. UNDERTAKER J. H. Sanditz
ADDRESS 944 South

N. B.—Every item of information 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.

1934

PARENTS

**MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Vernon
Township
City Deerfield (No. _____)

Registration District No. 870
Primary Registration District No. 5424

File No. 7538
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(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 w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 26 - 1898

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

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 _____ 19 1900 1/10 1900 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 11 1934

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____. I last saw h_____ alive on _____, 19____. Death is said to have occurred on the _____ m. above, at _____ m.

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

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) _____, M. D.
(Address) _____

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-1538