

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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 Bates  
Township Deer Creek  
City Adrian (No. \_\_\_\_\_)

Registration District No. 47  
Primary Registration District No. 3-070

File No. 7746  
Registered No. 10  
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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug-3-1924

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
7 7 11

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. School  
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) Adrian Mo

13. NAME James L. McCoy

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Adrian Mo

15. MAIDEN NAME Eva Moudy

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Adrian Mo

17. INFORMANT Alfred W. Moudy  
(ADDRESS) 5140-crest - R.C. Mo.

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Deer Creek Hill DATE 3/16 1934

19. UNDERTAKER Creath & Siff  
(ADDRESS) Adrian

20. FILED April 7 19 Mrs Pearl Cherry  
Registrar

**5 MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar-14 1934

22. I HEREBY CERTIFY, That I attended deceased from Feb. 10 1934, to March 14 1934

I last saw her alive on March 14 1934 Death is said to have occurred on the date stated above, at 4:25 A.M.

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

Flu-Whooping cough. General Bacteremia resulting in thrombosis of gastric blood vessel with perforation and extreme hemorrhage. Date of onset \_\_\_\_\_

Other contributory causes of importance: \_\_\_\_\_

Name of operation none Date of \_\_\_\_\_  
What test confirmed diagnosis? blood Was there an autopsy? no

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) E. E. Robinson M. D.  
(Address) Adrian, Missouri

