

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

Do not use this space.

**1. PLACE OF DEATH**

County Cass Registration District No. 156  
Township Peculiar Primary Registration District No. 5220  
City \_\_\_\_\_ No. \_\_\_\_\_ Ward \_\_\_\_\_

File No. 8195  
Registered No. 19

**2. FULL NAME**

(a) Residence, No. "COUNTRY HOME" St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode) \_\_\_\_\_ (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 1 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) Single  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Don't know 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
73 x x

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Donat of Co. Home  
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) Illinois

MOTHER FATHER 13. NAME Unknown

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

15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) W R Shelton  
Harrisonville Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Orend Cemetery DATE 3/3 1934

19. UNDERTAKER (ADDRESS) Remmington Brothers  
Harrisonville Mo.

20. FILED H 1934 A. S. S. Registrar \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 2 1934

22. I HEREBY CERTIFY, That I attended deceased from Mar 1, 1934, to Mar 2, 1934  
I last saw him alive on Mar 2, 1934 Death is said to have occurred on the date stated above, at 11 P. m.

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

Cerebral Apoplexy Date of onset \_\_\_\_\_

Other contributory causes of importance: 8291

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 \_\_\_\_\_, 1934

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. M. Gutter, M. D.  
(Address) Crestwood Mo  
County Physician

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.

*Dr. Gutter*

