

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

APR 25 1934

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

Do not use this space.

11679

1. PLACE OF DEATH

County Linn  
Township Clinton  
City Empo

Registration District No. 1027  
Primary Registration District No. 6136

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
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 61 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 <u>Martha Willoughby</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>5-11-1866</u>		
7. AGE	YEARS <u>67</u>	MONTHS <u>10</u>
	DAYS <u>18</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>Merchant &amp; Dealer</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
MOTHER	10. Date deceased last worked at this occupation (month and year) _____	
	11. Total time (years) spent in this occupation _____	
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Marion Co Mo</u>	
	13. NAME <u>John W Willoughby</u>	
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Nashville Tenn</u>	
	15. MAIDEN NAME <u>Elizabeth H. Roberts</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Tenn</u>	
	17. INFORMANT (ADDRESS) <u>Mrs Nellie Bushong Springfield Mo</u>	
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Marion Mo</u> DATE <u>3/30</u> 19 <u>34</u>		
19. UNDERTAKER (ADDRESS) <u>None</u>		
20. FILED <u>150</u> 19 <u>34</u> <u>J D Weatherman</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-29 1934

22. I HEREBY CERTIFY, That I attended deceased from 3/29 1934 to 3/29 1934  
I last saw him alive on 3/29 1934 Death is said to have occurred on the date stated above, at 9:30 p.m.  
The principal cause of death and related causes of importance were as follows:  
Acute intestinal complications Date of onset 3/28  
1909  
97

Other contributory causes of importance:  
Arteriosclerosis

Name of operation None Date of \_\_\_\_\_  
What test confirmed diagnosis? Clinical 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. M. Hubbard M. D.  
(Address) Marion Mo



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County St. Louis  
Township Clinton  
City St. Louis (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward)

Registration District No. 1027  
Primary Registration District No. 6126

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

**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)

A. A. Willoughby

**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) \_\_\_\_\_

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. _____	11. Total time (years) spent in this occupation _____
	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) _____	

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 Jan 11 1934 J. Ormuthman Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 29 1934

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_. I last saw h. \_\_\_\_\_ 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:

acute intestinal complications  
subacute  
chronic enteritis  
or infectious colitis

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

Name of operation 1200 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. A. Hubbard M. D.  
(Address) 1200

SUPPLEMENTARY

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

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