

MAY 25 1934

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County Wayne
 Township Wayne
 City Wayne

Registration District No. 822
 Primary Registration District No. 8541

File No. 15548
 Registered No. 8
 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 25-1858

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
76 1 1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired farmer
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) West Virginia
 (STATE OR COUNTRY)

10. NAME OF FATHER John Abshire

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't Know
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Nancy Johnson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Don't Know
 (STATE OR COUNTRY)

14. INFORMANT Easner Abshire, Son
 (Address)

15. FILED April 24 1934 Mo. Health Dept.
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 26 1934

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____, _____, _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS: 1

No physician
Caused death was
paralytic stroke. Second
stroke. He did not want
physician.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) John E. Abshire, M. D.Apr. 19 24 (Address) Williamsport Mo.

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Lillie Lake Cem April 27 1934
 20. UNDERTAKER None ADDRESS _____

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.

