

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

Do not use this space.

1. PLACE OF DEATH

County Leann Registration District No. 497 File No. 17354
 Township North Salem Primary Registration District No. 3672 Registered No. _____
 City _____ (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 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 Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 13 - 1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
61 1 18

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

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) Mo.

13. NAME Nathan Cordroy

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

15. MAIDEN NAME Mary Boyd

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

17. INFORMANT (ADDRESS) James A. Cordroy

18. BURIAL, CREMATION, OR REMOVAL PLACE North Salem DATE June 2, 1934

19. UNDERTAKER (ADDRESS) W. H. McCollum

20. FILED 6/13 1934 Julia M. McCormick Registrar

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 31 1934

22. I HEREBY CERTIFY, That I attended deceased from May 2 1934 to May 31 1934

I last saw him alive on May 30 1934 Death is said to have occurred on the date stated above, at 7 P. m.

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

Dilatation of pericardium caused not of coronary on account of heart

Other contributory causes of importance Dilatation of heart

Name of operation None Date of _____

What test confirmed diagnosis? _____ Was there an autopsy?

23. If death was due to external cause (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? No

If so, specify _____

(Signed) B. A. Decker, M. D.

(Address) 1111 1/2

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.

JUL 13 1934

B1
B1
D9

Renn

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

WASHINGTON

E. T. McLaugh, M. D.,
Special Agent,
Jefferson City, Mo.

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: S. A. Cardway
Who died at _____ on May 31 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex M Color or race W Single, married, widowed or divorced: _____

Date of birth _____ Age: Years 61 Months 1 Days 18

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month Sept Year 34

Birthplace (State or country) Lin Co Mo

Birthplace of father (State or country) Sept Mo

Birthplace of mother (State or country) Sept Mo

Principal cause of death: Myocarditis ruptured

Other contributory causes of importance Deilitation of heart

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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 _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician E. P. Baker M.D.

Address of physician Springer Mo

Signature of Registrar Flora M McCormick

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 497

Primary Reg. Dist. No. 5672

Very truly yours,
E. J. McLaughlin M.D.
J.C.

Special Agent.

