

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.

AUG 23 1935

25157 *J*

**1. PLACE OF DEATH**

County *Jefferson*  
Township *Waller*  
City *Desate*

Registration District No. *420*  
Primary Registration District No. *3022*

File No. \_\_\_\_\_  
Registered No. ~~5162~~ *62*  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

*Minnie E. Style*

(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 *F.* 4. COLOR OR RACE *W.* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *widowed*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug 16 - 1882*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<i>81</i>	<i>11</i>	<i>05</i>		

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

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) *Anna Springs Mo.*

13. NAME *George Graham*

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

15. MAIDEN NAME *Not known*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Not known*

17. INFORMANT *Cornet Style 708 H 58*  
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19 \_\_\_\_\_

19. UNDERTAKER *Richardson Motherhead*  
(ADDRESS) *Desate Mo.*

20. FILED *7/23* 19 *34* *J. W. Morris*  
Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *July 28* 19 *34*

22. I HEREBY CERTIFY, That I attended deceased from *July 21* 19 *34* to *July 21* 19 *34*  
I last saw him alive on *July 21* 19 *31* Death is said to have occurred on the date stated above, at *3:40 p.m.*

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

*Heat Exhaustion*

*191 / 31*

Other contributory causes of importance:

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 \_\_\_\_\_ 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) *David Ford* M. D.

(Address) *Desate Mo.*

