WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

AUG 14 1934

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

Do not use this space.

File No. 27996
Registered No. 10

1. PLACE OF DEATH
County: Sullivan — Registration District No. 849
Township: Buchanan — Primary Registration District No. 6123
City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME Deverne Devolld

(a) Residence, No. ..... St., ... Ward. ..... (If nonresident, give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
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): 4-19-33

7. AGE: Years 1 — Months 3 — Days 4 — If LESS than 1 day, ... hrs. or ..... min.

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

FATHER
13. NAME: Dewey Devolld
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo.

MOTHER
15. MAIDEN NAME: Susie Campbell
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mo.

17. INFORMANT (ADDRESS): Roger White, Milan, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Green City DATE: 7-23 1934

19. UNDERTAKER (ADDRESS): Glenn E. Kent, Green City, Mo.

20. FILED 7-24 1934 Virginia Gibson, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): July 23, 1934

22. I HEREBY CERTIFY, That I attended deceased from July 22, 1934, to July 23, 1934, I last saw him alive on July 22, 1934. Death is said to have occurred on the date stated above, at 4 a. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Pneumonia (Broncho.)	7/20/34

Other contributory causes of importance:

Name of operation: — Date of: —
What test confirmed diagnosis? Was there an autopsy? No

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? No
If so, specify
(Signed) D. M. Riggins, M. D.
(Address) Green City Mo.

#2 Sullivan
Buchanan

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
WASHINGTON

E. T. McGaugh, 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: Devine Devolld
Who died at _____ on July 23, 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 1 Months 3 Days 4

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 _____ Year _____
Birthplace (State or country) _____
Birthplace of father (State or country) _____
Birthplace of mother (State or country) _____
Principal cause of death: (Pneumonia Bronchis.
This O.K. there was nothing else)

Other contributory causes of importance _____
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 D M Riggins
Address of physician Green City Mo
Signature of Registrar Virginia Gibson Date filed 7-24-1934

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. 849

Primary Reg. Dist. No. 6123

Very truly yours,
E. T. McGaugh
M. D.
Special Agent.

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