

SEP 6 1934

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

Do not use this space.

28710

## 1. PLACE OF DEATH

County

Township

City

Registration District No.

Primary Registration District No.

File No.

Registered No.

St.

Ward

## 2. FULL NAME

(a) Residence, No.

(Usual place of abode)

St.

Ward.

(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

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

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.

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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED

1934

Registrar

## MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from Aug 26, 1934 to Aug 26, 1934

I last saw him alive on Aug 26, 1934 Death is said to have occurred on the date stated above, at 5 P.M.

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

Automobile accident  
 cerebral hemorrhage  
 coronary

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

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

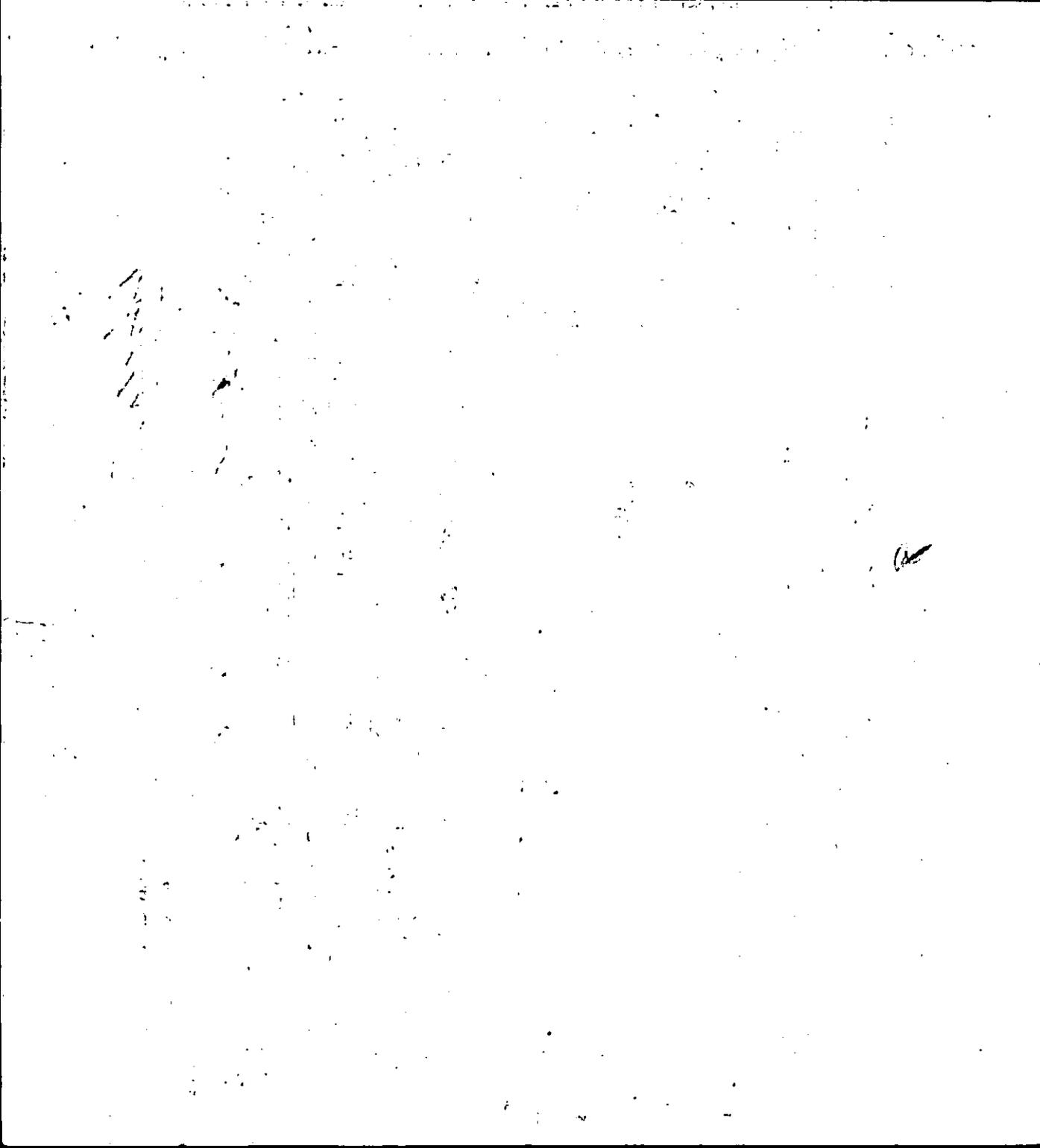
(Signed)

(Address)

WRITE PLAINLY, WITH UNFADE 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.

123



#2 *Clinton*

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
WASHINGTON

E. T. McLaugh, M. D.,  
#2 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: *Loran Wynne*  
Who died at \_\_\_\_\_ on *Aug - 26 - 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 *34* Months *4* Days *11*

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 \_\_\_\_\_  
*Auto-moblie accident*

Birthplace (State or country) *Cerebral Concussion*

Birthplace of father (State or country) *accident supposed to have been*

Birthplace of mother (State or country) *due to auto-moblie running at high*

Principal cause of death: *speed and going off pavement due to blowout*  
*tire in road, injuring blow named, who died in doctor's office later*

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

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_ *2/10*  
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 \_\_\_\_\_

Address of physician \_\_\_\_\_

( Signature of Registrar *W. H. Risley*) Date filed \_\_\_\_\_

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. *204*

Very truly yours,

Primary Reg. Dist. No. *3013*

*E. T. McLaugh, M.D.*  
Special Agent. *K.*

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