

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

Do not use this space.

SEP 19 1934

31623

1. PLACE OF DEATH

County Scott
Township Sylvania
City New Crow (No. _____)

Registration District No. 820
Primary Registration District No. 6069

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(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)

James C Bishop

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 2 1919

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>15</u>	<u>6</u>	<u>21</u>	

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

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) Swanee Mo

13. NAME Robert Bishop

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

15. MAIDEN NAME Nettie Hatfield

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

17. INFORMANT (ADDRESS) Wm Hatfield

18. BURIAL, CREMATION, OR REMOVAL
PLACE Carpenter DATE Aug 31 1934

19. UNDERTAKER (ADDRESS) H G Welch

20. FILED 9/16 1934 J. S. Chman Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 30 1934

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw h..... alive on _____, 19____. Death is said

to have occurred on the date stated above, at 1.08 m.

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

Tuberculosis of spine
Date of onset _____
Other contributory causes of importance: Paralysis, Invald since injury

Name of operation _____ Date of _____

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)

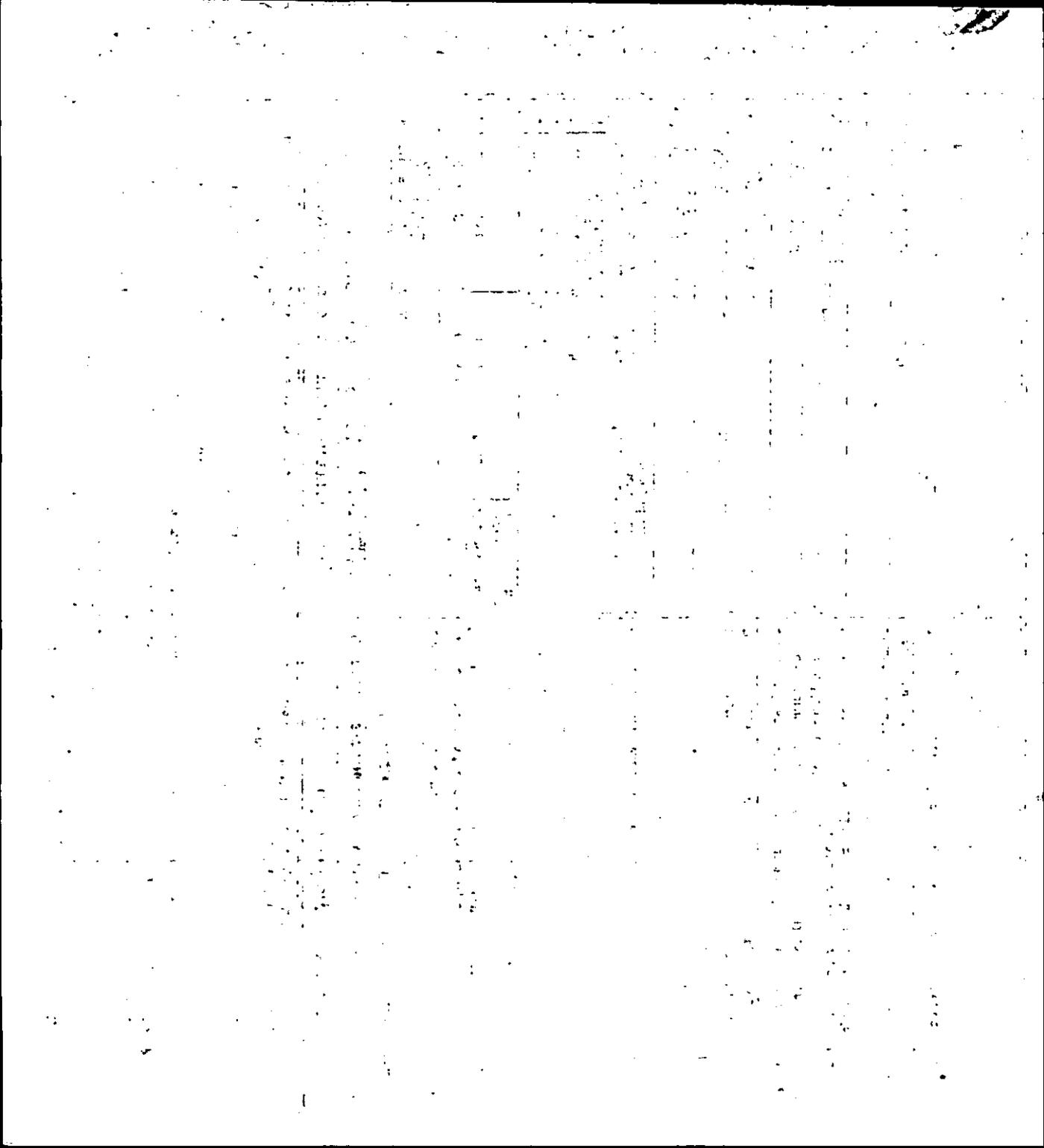
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____ Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? If so, specify _____

(Signed) H G Welch Carson
Scott Mo
(Address) Springfield Mo Co

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.



Scott

WASHINGTON

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: James C Bishop
Who died at _____ on Aug 30 - 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 15 Months 6 Days 21

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: Subclasses of Spine Month _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) T. B. Spinal Column

Birthplace of mother (State or country) _____

Principal cause of death: _____

Other contributory causes of importance Paralysis - Inhaled sense Infancy

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 _____

Address of physician Altkman 9/10/34

Signature of Registrar # 820 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.

Very truly yours,

E. T. McGaugh

State Registrar

Special Agent.

Reg. Dist. No. 820

Primary Reg. Dist. No. 6069

undertaker Henry Welsh. skenton Mo.

