

DEC 13 1934

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

Do not use this space.

1. PLACE OF DEATH

County *Cape Girardeau*Township *Central*City *Cameron* (No. _____) St. _____ Ward _____Registration District No. *204*Primary Registration District No. *3013*File No. *38875*Registered No. *56*

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 (write the word) *Widowed*5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Angeline Dwyer*6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *1-27-1857*7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *77 9 29*8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Mechanic*

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) *Ind*13. NAME *Gas Dwyer*14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *South Bend*15. MAIDEN NAME *Mary Parker*16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *South Bend*17. INFORMANT (ADDRESS) *G. Dwyer
Cameron Mo*18. BURIAL, CREMATION, OR REMOVAL PLACE *Cameron Mo* DATE *2-28 1934*19. UNDERTAKER (ADDRESS) *Old Mansions
Cameron Mo*20. FILED *Nov 28th 1934* *D. C. Riley* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Nov 26, 1934*22. I HEREBY CERTIFY, That I attended deceased from *Nov 25, 1934* to *Nov 26, 1934*I last saw him alive on *Nov 25, 1934* Death is saidto have occurred on the date stated above, *11:30 p.m.*

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

*Chronic Gastritis
Nephritis* Date of onset *Nov 13*Other contributory causes of importance: *731*Name of operation _____ Date of _____
What test confirmed diagnosis? *Urinary* 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) *A. O. Gilliland* M. D.(Address) *Cameron Mo*

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.

