

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

Do not use this space.

RECEIVED FEB 27 1935

1. PLACE OF DEATH

County Clark
Township Bayou
City Bakersfield, Mo.

Registration District No. 647
Primary Registration District No. J-857

File No. 2300
Registered No. _____
St. _____ Ward _____

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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male | 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) Dec. 29, '34

7. AGE YEARS MONTHS DAYS | IF LESS than 1 day, _____ hrs. or _____ min.
11

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Bakersfield, Mo
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Mose Willis

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Tenn
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Ida Brannum

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ky
(STATE OR COUNTRY)

14. INFORMANT Mose Willis
(Address) Bakersfield, Mo

15. FILED 1-9, 35 CA Beach
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 9, 1935

17. I HEREBY CERTIFY, That I attended deceased from Jan 8, 1935, to Jan 9, 1935, that I last saw him alive on Jan 8, 1935, and that death occurred, on the date stated above, at 2 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia

10 7 2
(duration) yrs. mos. 4 da.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? stethoscope

(Signed) CA Beach, M. D.

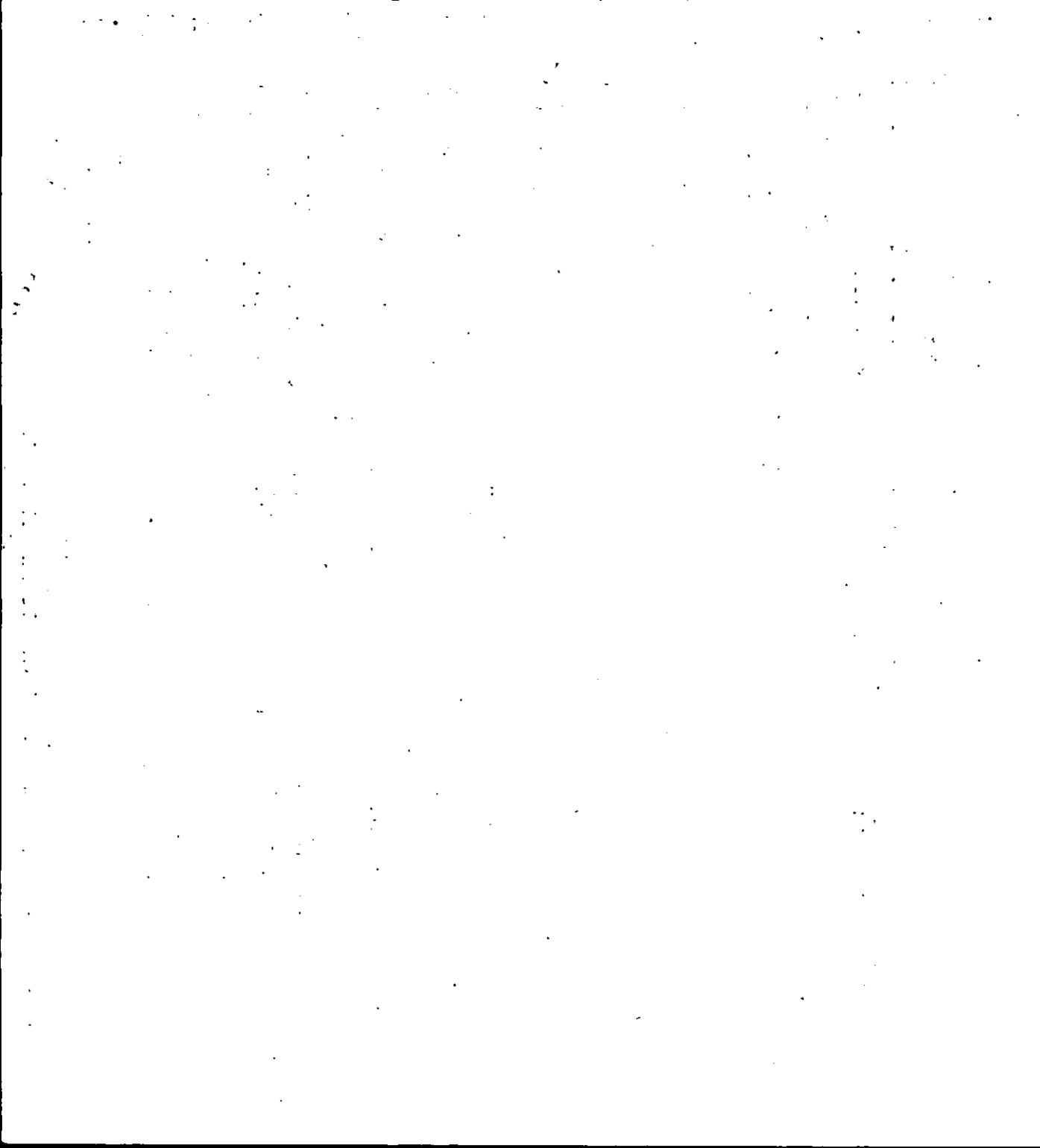
1-9, 1935 (Address) Elijah, Mo

*State the DISEASE CAUSING DEATH, or if deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Bakersfield Cemetery DATE OF BURIAL 1-9, 1935

20. UNDERTAKER Morris Bros ADDRESS Bakersfield

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.



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Ozark Registration District No. 647 File No. _____
 Township _____ Primary Registration District No. _____ Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

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

MEDICAL CERTIFICATE OF DEATH

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S
 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. 7 0 11

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 9, 1935
 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 _____ m.
 The principal cause of death and related causes of importance were as follows:

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 _____

pneumonia
1070
 Other contributory causes of importance:
No contributory causes.
 Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

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.

MOTHER 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
 17. INFORMANT (ADDRESS) _____

Manner of injury _____
 Nature of injury _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____, 19____

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

19. UNDERTAKER (ADDRESS) _____
 20. FILED Jan 10 35 CA Beach Registrar.

(Signed) _____, M. D.
 (Address) _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPERVISOR

