

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

Do not use this space *W*

MAR 23 1935

1. PLACE OF DEATH

County Dent
Township Sinkin
City (No.)

Registration District No. 954
Primary Registration District No. 5368

File No.
Registered No. 12 St. Ward

2. FULL NAME Green W Bay

(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)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 4 1843

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
92 1 2

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

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) St. Francis Co Mo

13. NAME Wm Ning Bay

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

15. MAIDEN NAME Nancy Johns

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

17. INFORMANT Jim Bay (ADDRESS) Bunker Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Bay Cem DATE 2/8/35

19. UNDERTAKER Carl K Spencer (ADDRESS) Salem Mo

20. FILED 2/2/35 M. E. Ruddle Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 6th 19 35

22. I HEREBY CERTIFY, That I attended deceased from one July 4 19 35 to July 5th 19 35

I last saw him alive on July 4 19 35 Death is said to have occurred on the date stated above, at 5:00 P. M.
The principal cause of death and related causes of importance were as follows:

Senility Date of onset

Other contributory causes of importance: Uremia

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 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) J. L. Lusk M. D.
(Address) Salem 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.

12 FEB 1950

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

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Louis

Township St. Louis

City St. Louis (No. 954)

Registration District No. 954

Primary Registration District No. 5268

File No. 12

Registered No. 12

St. St. Louis Ward 12

2. FULL NAME

(a) Residence, No. Green W Bay

(Usual place of abode)

St. St. Louis Ward 12

(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

m

4. COLOR OR RACE

w

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

m

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

Chelena Copeland

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

Jun 4 - 1843

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, hrs.
or min.

92

1

2

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

Farmers

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)

St. Francis Co
Mo

13. NAME

Nancy Bay

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

St. Francis Co
Mo

15. MAIDEN NAME

Nancy Johns

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

Penn

17. INFORMANT
(ADDRESS)

Jim Bay
Rutherford Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE

Bay Cem

DATE

2/8

1935

19. UNDERTAKER
(ADDRESS)

Charles Spencer
St. Louis Mo

20. FILED

May 2

1935

Charles Spencer
St. Louis Mo

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 6, 1935

22. I HEREBY CERTIFY, That I attended deceased from Feb 4, 1935, to Feb 6, 1935

I last saw him alive on Feb 4, 1935. 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:

Senility

Nephritis (Chronic)

Other contributory causes of importance

Arteriosclerosis

131

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, 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) J. O. Lucke, M. D.

(Address) St. Louis Mo

APR 26 1935

MAY 2 2 1935

S-4872

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.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY

1. PLACE OF DEATH

County Dunk

Registration District No. 954

Township

Primary Registration District No. 5368

City

(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

m

4. COLOR OR RACE

w

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

m

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.

92

1

2

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)

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.

19. UNDERTAKER
(ADDRESS)

20. FILED

May 2 1935

Abelchia Pick
Registrar

MEDICAL CERTIFICATE OF DEATH

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

Feb. 6 1935

22. I HEREBY CERTIFY, That I attended deceased from

_____, 19____, to _____, 19____

I last saw him _____ 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:

Date of onset

Other contributory causes of importance:

premia
chronic nephritis also bowen
refused to continue to act

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 _____, 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) J. P. Ficke _____, M. D.

(Address) O. Salem Mo

89
(52) - 4872