MAR 28 1935

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

10331

1. PLACE OF DEATH
County St. Francois — Registration District No. 772 — File No. 176
Township ~~St. Francois~~ — Primary Registration District No. 4463 — Registered No.
City Elvins (No. St. Ward)

2. FULL NAME Joseph Lester
(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 20 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): Married

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF ~~(or) WIFE OF~~ Catherine Lester

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 9th 1859

7. AGE: Years 75 — Months 2 — Days 25 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Odd Jobs
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Crawford Co
(STATE OR COUNTRY) Mo

PARENTS
10. NAME OF FATHER John Lester
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Nancy Clinton
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Unknown

14. INFORMANT Catherine Lester
(Address) Elvins Mo

15. FILED 3/5 1935 B B Farrar M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-4-1935

17. I HEREBY CERTIFY, That I attended deceased from 1-4, 1935, to 3-4, 1935, that I last saw him alive on 3-3, 1935, and that death occurred, on the date stated above, at 7 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
myocarditis: Chr.
Bronchitis: Chr.
arterio-sclerosis
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED No
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) B B Farrar, M. D
, 19 (Address) Flat River Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Pendleton Cemetery Mo — DATE OF BURIAL 3-5-35
20. UNDERTAKER Caldwell Bros — ADDRESS Flat River 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.

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

1. PLACE OF DEATH

County..... Registration District No..... 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

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. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

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

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.....ds.

CONTRIBUTORY
(SECONDARY) .....

.....(duration).....yrs. .....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

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

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

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.