

JUL 29 1935

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

Do not use this space.

21834

1. PLACE OF DEATH

County Scott

Township Lickston

City Lickston, Mo. (No.)

Registration District No. 821

Primary Registration District No. 4553

File No.

Registered No.

St. Ward)

2. FULL NAME

(a) Residence, No. Lickston, Mo. St. Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 22 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 Female 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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 21-1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or min. 75 10 30

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Life 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)

FATHER 13. NAME Ada Dugher

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

MOTHER 15. MAIDEN NAME Elizabeth Myers

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

17. INFORMANT (ADDRESS) Eddie Clinton

18. BURIAL, CREMATION, OR REMOVAL Lickston City Cemetery PLACE DATE June 24, 1935

19. UNDERTAKER (ADDRESS) H. J. Welsh Lickston, Mo.

20. FILED July 5, 1935 W. H. Pressnell Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 22, 1935

22. I HEREBY CERTIFY that I attended deceased from June 22, 1935, to June 22, 1935. I last saw him alive on June 22, 1935. Death is said to have occurred on the date stated above, at 10 P. m.

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

Chronic Cardiac Valvular Disease Date of onset

Other contributory causes of importance

Name of operation Chloroform Date of

What test confirmed diagnosis? Chloroform 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

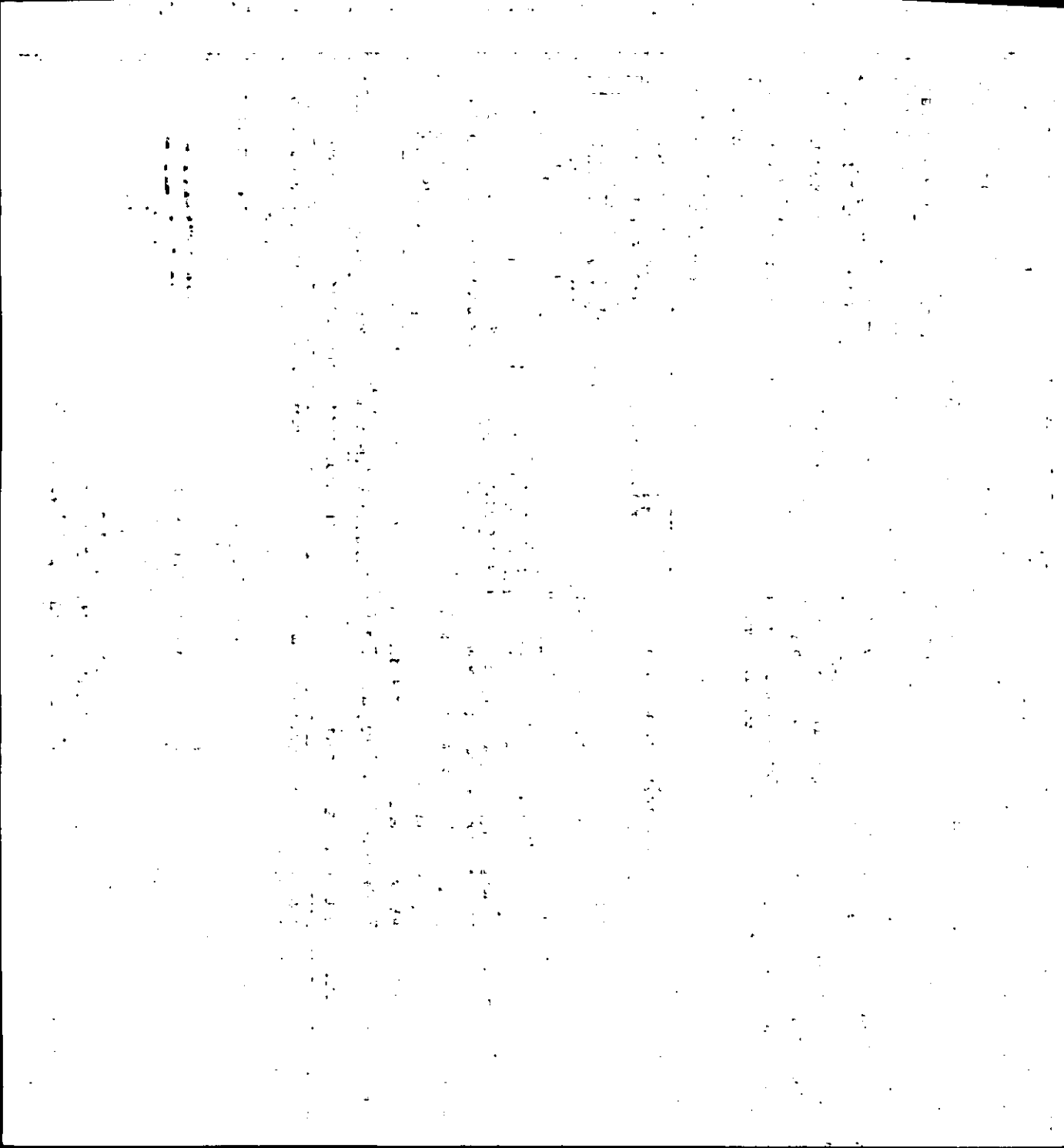
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Thompson E. M. Cure, M. D.

(Address) Lickston, Mo.



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Scott
Township Lincolnton
City Lincolnton (No. _____ St. _____ Ward _____)

Registration District No. 821
Primary Registration District No. 821-3

File No. _____
Registered No. _____

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)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 1887

7. AGE YEARS 74 MONTHS 4 DAYS 14 If LESS than 1 day, _____ hrs. or _____ min.

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 10-8 1935 W. H. Oranell Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 22, 1935

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

I first 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:

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) _____, M. D.

(Address) _____

OCT 7 1935

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