

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

AUG 12 1935

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

Do not use this space.  
25253

1. PLACE OF DEATH

County Spring  
Township Grand Pass  
City (No. \_\_\_\_\_) \_\_\_\_\_

Registration District No. 795  
Primary Registration District No. 795

File No. \_\_\_\_\_  
Registered No. 795 St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

Julia Persinger  
(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 <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>7-15-1931</u>				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
		<u>3</u>	<u>16</u>	
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>X</u>			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>X</u>			
	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) <u>Shiloh Mo</u>				
MOTHER	13. NAME <u>Melburn Persinger</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Shiloh Mo</u>			
	15. MAIDEN NAME <u>Margaret Nash</u>			
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Shiloh Mo</u>				
17. INFORMANT (ADDRESS) <u>J. M. Persinger</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Grand Pass Cem</u> DATE <u>7/16/35</u>				
19. UNDERTAKER (ADDRESS) <u>Willis Funeral Home</u>				
20. FILED <u>7-16-</u> 19 <u>35</u> <u>J. M. Persinger</u> Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-15, 1935

22. I HEREBY CERTIFY, That I attended deceased from 7-8, 1935, to 7-15, 1935. I last saw him alive on 7-15, 1935. Death is said to have occurred on the date stated above, at 10:20 a.m. The principal cause of death and related causes of importance were as follows:  
Marasmus  
Date of onset \_\_\_\_\_

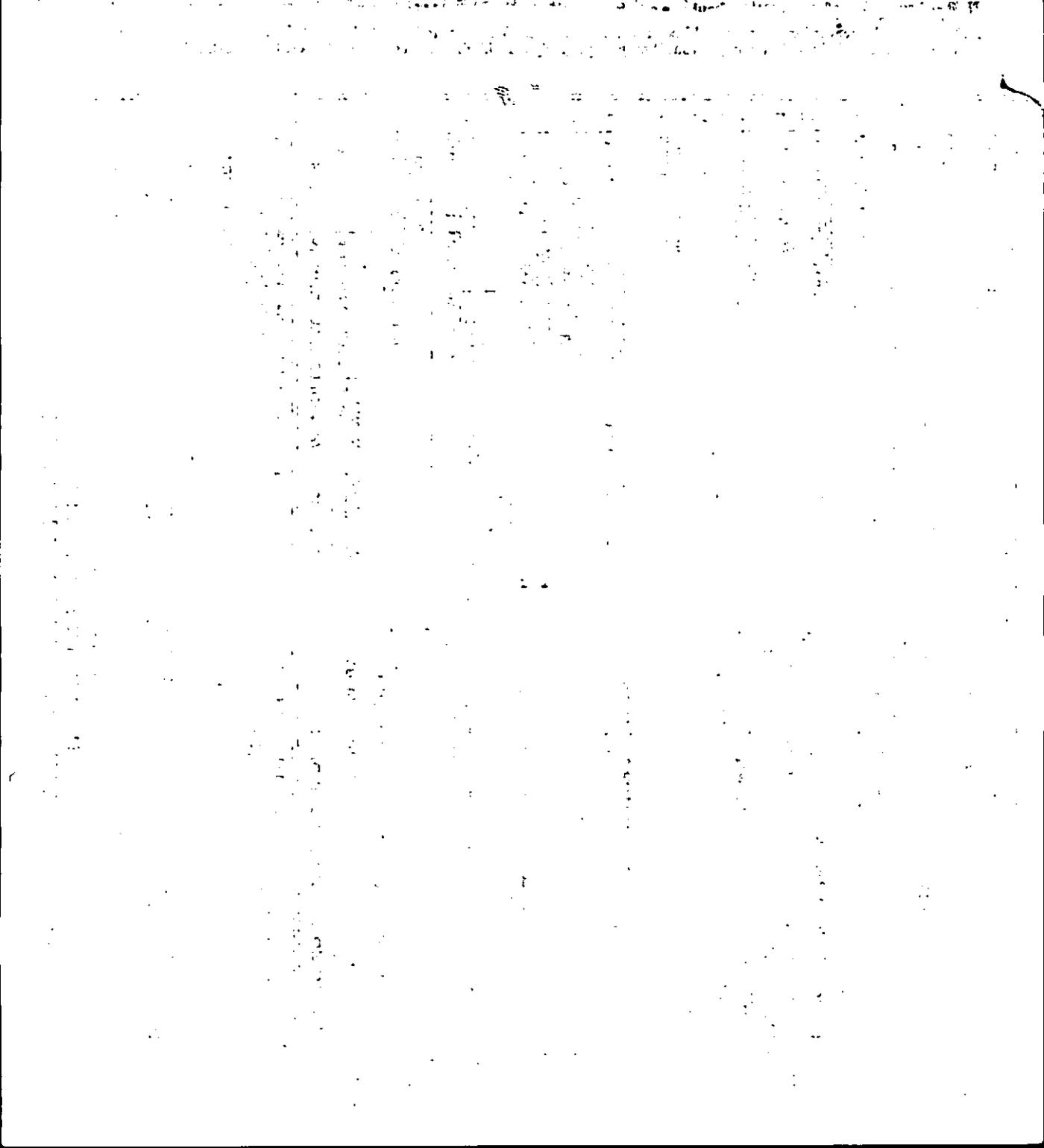
Other contributory causes of importance: 10

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 George F Jones, M. D.  
(Signed) \_\_\_\_\_ (Address) Waverly Mo



**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 Saline  
Township \_\_\_\_\_  
City \_\_\_\_\_ (No. \_\_\_\_\_)

Registration District No. 795  
Primary Registration District No. 6238

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**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) S

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 29 1838

7. AGE YEARS MONTHS DAYS 97 3 15 15 15 15 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) Saline Co

13. NAME William Persinger

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

15. MAIDEN NAME Mabel Nash

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

17. INFORMANT Wm Persinger (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL PLACE Grand Mass DATE July 16 1935

19. UNDERTAKER (ADDRESS) Waller Funeral Home  
Carrollton Mo

20. FILED July 16 1935 Raymond Spencer Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 15 1935

22. I HEREBY CERTIFY, That I attended deceased from 7-8 1935 to 7-15 1935  
I last saw h. w. alive on 7-15 1935 Death is said

to have occurred on the date stated above, at 6:29 a.m.  
The principal cause of death and related causes of importance were as follows:

Date of onset \_\_\_\_\_  
\_\_\_\_\_ M was found \_\_\_\_\_  
\_\_\_\_\_ 158 \_\_\_\_\_  
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 None  
(Signed) Wm Persinger M. D. O.  
(Address) Waverly 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.

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