

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

Do not use this space.

SEP 26 1935

28411

1. PLACE OF DEATH
 County Scott Registration District No. 820 879 File No. 6068
 Township Mooley Primary Registration District No. 6069 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Milford Oscar Helms
 (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 male
 4. COLOR OR RACE w
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
8/11/93

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6/12/94

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
42 2 15

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

9. BIRTHPLACE (CITY OR TOWN) Solsbury
 (STATE OR COUNTRY) 2nd

10. NAME OF FATHER L O Helms

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Berkswell
 (STATE OR COUNTRY) 2nd

12. MAIDEN NAME OF MOTHER Louise Workman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Tulip
 (STATE OR COUNTRY) 2nd

14. INFORMANT L O Helms
 (Address) Mooley mo

15. FILED 7/10/35 J. H. K. K. K. REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/26 1935

17. I HEREBY CERTIFY, That I attended deceased from on 8/26, 1935, that I last saw him alive on 8/26, 1935, and that death occurred, on the date stated above, at 5:15 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pernicious malaria
 (duration) _____ yrs. _____ mos. 3 ds.

CONTRIBUTORY (SECONDARY) NO
 (duration) _____ yrs. _____ mos. _____ ds.

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 _____
 (Signed) J. A. Clum, M. D.
 (Address) Oran 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mooley Cemetery DATE OF BURIAL 8/25 1935

20. UNDERTAKER W. S. Heisero Co. ADDRESS Oran mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

