

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

Do not use this space.

NOV 20 1935

32271

1. PLACE OF DEATH

County Warren
Township Clinton
City Clinton (No. _____)

Registration District No. 230
Primary Registration District No. 5312

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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Annie Byrd</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Sept 24th 1862</u>		
7. AGE	YEARS <u>73</u>	MONTHS <u>0</u>
	DAYS <u>26</u>	If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Farming Rd</u>	
	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 _____	
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Sedalia Mo</u>	
	13. NAME <u>Bothem Byrd</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Sedalia Mo</u>	
MOTHER	15. MAIDEN NAME <u>Annie Cole</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Sedalia Mo</u>	
17. INFORMANT (ADDRESS) <u>Mrs. Yes, Haver, 200</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Funeral Home</u> DATE <u>Oct. 27th 1935</u>		
19. UNDERTAKER (ADDRESS) <u>J. C. Hester, Clinton Mo</u>		
20. FILED <u>Nov 10th 1935</u> <u>J. G. R. Jones</u> Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 20th 193522. I HEREBY CERTIFY, That I attended deceased from 9/6/35, 1935, to 10/20/35, 1935

I last saw him alive on 10/20/35, 1935. Death is said to have occurred on the date stated above, at 1:35 A.M.

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

Date of onset

Senility
AM

Other contributory causes of importance:

Keenly pleurisy
due to pleurisy - sclerosis

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 _____, 1935

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. G. R. Jones, M. D.(Address) Clinton, Mo

