

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.

JAN 15 1936 MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

38757

## 1. PLACE OF DEATH

County Butler  
Township Capps  
City                      (No.                      St.                      Ward                     )

Registration District No. 980  
Primary Registration District No. 5132

File No.                       
Registered No.                     

## 2. FULL NAME

(a) Residence, No. A. P. #1  
(Usual place of abode)

St.                      Ward                     

(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<br><u>M.</u>                                                                         | 4. COLOR OR RACE<br><u>W.</u> | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)<br><u>Single.</u> |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>                    </u>    |                               |                                                                             |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Nov. 24 - 35</u>                                 |                               |                                                                             |
| 7. AGE YEARS                                                                                | MONTHS                        | DAYS                                                                        |
|                                                                                             |                               | <u>21</u>                                                                   |
|                                                                                             |                               | If LESS than 1 day, hrs. or min.                                            |
| 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. |                               | <u>Baby</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                             |

12. BIRTHPLACE (CITY OR TOWN) Butler Co.  
(STATE OR COUNTRY) Mo.

13. NAME Not known

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

15. MAIDEN NAME Edna May Wisecarver

16. BIRTHPLACE (CITY OR TOWN) Butler Co.  
(STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Geo. Wisecarver  
Poplar Bluff Mo.

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Shiloh DATE 12-15 1935

19. UNDERTAKER (ADDRESS) Frank M. M. Co.  
Poplar Bluff Mo.

20. FILED 12/15 1935 AM 5 Butler Co.  
Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-15 1935

22. I HEREBY CERTIFY, That I attended deceased from                     , 19                    , to                     , 19                    .

I last saw h.                      alive on                      19                    . Death is said

to have occurred on the date stated above, at 2:30 A. M.

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

Malnutrition

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) Dr. M. Spaulding, M. D.

(Address) Poplar Bluff 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

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY

## 1. PLACE OF BIRTH

County ButlerRegistration District No. 980

File No. \_\_\_\_\_

Township \_\_\_\_\_

Primary Registration District No. 5132

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 F 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 \_\_\_\_\_

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 0 0 21

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 1/23 1926 M. S. Caldwell Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 15, 1931

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw h. \_\_\_\_\_ 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:

Maturation  
Syphilis

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) Wm. Spanning, M. D.(Address) Poplar Bluff, Mo

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