JAN 15 1935

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

38886

. PLACE OF DEATH

County CARTER — Registration District No. 145 — File No. 18

Township JOHNSON — Primary Registration District No. 5208 — Registered No. 8

City ~~ELLSINORE~~ (No. ; St. Ward)

. FULL NAME EDWARD BERNARD JOY

(a) Residence. No. ELLSINORE St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

ngth of residence in city or town where death occurred 6 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
ALE	WHITE	MARRIED

IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF
GRACE CATHERINE TIRY

DATE OF BIRTH (MONTH, DAY AND YEAR) MAY 31, 1863

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
71 ~~72~~		6 ~~7~~	18 ~~19~~	

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) FARM

(c) Name of employer

IRTHPLACE (CITY OR TOWN) HOOSIC FALLS
(STATE OR COUNTRY) NEW YORK

0. NAME OF FATHER ABRUM HENRY JOY

1. BIRTHPLACE OF FATHER (CITY OR TOWN) ??
(STATE OR COUNTRY) NEW YORK

2. MAIDEN NAME OF MOTHER MARY O'CONNOR

3. BIRTHPLACE OF MOTHER (CITY OR TOWN) ??
(STATE OR COUNTRY) NEW YORK

NFORMANT GRACE CATHERINE JOY
(Address) ELLSINORE

FILED 12/20, 1935 Alexander Johnston
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) DEC. 19, 1935

17. I HEREBY CERTIFY, That I attended deceased from DEC. 15, 1935, to DEC. 19, 1935 that I last saw him alive on DEC. 19, 1935, and that death occurred, on the date stated above, at EIGHT A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
LOBAR PNEUMONIA

108

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (SECONDARY) ACUTE NEPHRITIS

(duration) yrs. mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? ELLSINORE

DID AN OPERATION PRECEDE DEATH? NO. DATE OF

WAS THERE AN AUTOPSY? NO.

WHAT TEST CONFIRMED DIAGNOSIS? NONE URINE TEST

(Signed) Dr. John H. Nuhn, D.O.

, 19 (Address) Hunter, Missouri

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
HUNTER, MO.,	12 22 1935
20. UNDERTAKER	ADDRESS
MR. CROY	VAN BUREN

MARGIN RESERVED FOR BINDING

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.

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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.

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

1. PLACE OF DEATH

County..... Registration District No..... File No. 18

Township..... Primary Registration District No..... Registered No. 8

City..... (No. ....., ... St. ..... W

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

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.

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

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

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to ....., 1
that I last saw h..... alive on....., 19....., a
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSE (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICI HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BU

20. UNDERTAKER | ADDRESS