

FEB 3 1935

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space

1. PLACE OF DEATH

County Greene Registration District No. 318
 Township Wagon Wheel Primary Registration District No. 2001

File No. 39302
 Registered No. 740
 St. _____ Ward)

2. FULL NAME

(a) Residence, No. 892 26 Lawrence 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 White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Nellie Bryant
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 3 1874
 7. AGE YEARS 52 MONTHS 11 DAYS 24 If LESS than 1 day, _____ hrs. or _____ min.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-27-1935
 22. I HEREBY CERTIFY, That I attended deceased from Dec 15, 1935, to Dec, 1935
 I last saw him alive on Dec 24, 1935 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:

OCCUPATION
 8. Trade, profession, or particular kind of work done, as printer, sawyer, bookkeeper, etc. Librarian
 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

Date of onset
C. V. R. Syndrome
 Other contributory causes of importance:
None

MOTHER FATHER
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTY) Greene County, Mo
 13. NAME Samuel Aubrey
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Greene Co Mo
 15. MAIDEN NAME Miss Jane Bryant
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? Yes

17. INFORMANT (ADDRESS) Nellie Bryant
 18. BURIAL, CREMATION, OR REMOVAL PLACE Wagon Wheel DATE Dec 28 1935
 19. UNDERTAKER (ADDRESS) Wagon Wheel
 20. FILED 12-28-35 R. W. Langston Registrar.

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? Yes
 If so, specify C. V. R. Syndrome
 (Signed) E. L. G. Gentry M. D.
 (Address) 214 1/2 W. Jefferson

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.

