

3 1936

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

Do not use this space.

38374

1. PLACE OF DEATH

County Marion  
Township Round Grove  
City Georgetown

Registration District No. 551  
Primary Registration District No. 5747

File No. ....  
Registered No. 6 St. .... Ward)

2. FULL NAME

George Washington Lindsey

(a) Residence, No. Cuba, Mo. St., ..... Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF Angeline Belle Lindsey

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
90. 90 5 0

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired farmer  
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) Hester Mo.

13. NAME Alexander Lindsey

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

15. MAIDEN NAME Rebecca Wiseman

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Vir.

17. INFORMANT (ADDRESS) Mrs. Minnie Vanarsdel  
Nelsonville, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Hester, Mo DATE Oct. 29 1936

19. UNDERTAKER (ADDRESS) Thomas Ball  
Cuba, Mo.

20. FILED 10 28 1936 J. M. Crebs Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 27 1936

22. I HEREBY CERTIFY, That I attended deceased from Oct. 11 1936 to Oct 27 1936  
I last saw him alive on Oct 15 1936 Death is said to have occurred on the date stated above, at 12:30 p.m.

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

mitral stenosis

Date of onset 1934

Other contributory causes of importance:

Acute poisoning  
Senility

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

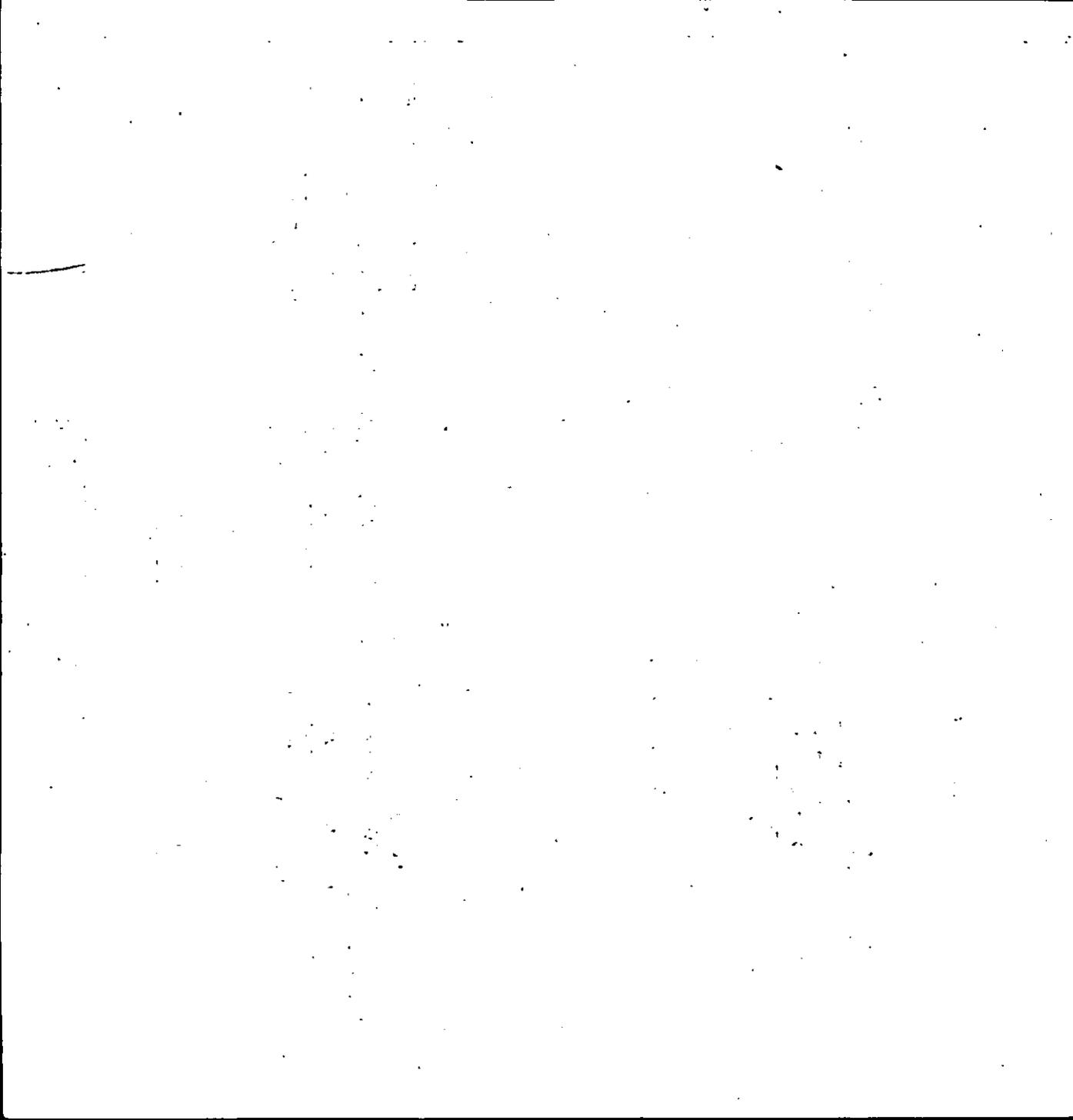
23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ..... Date of injury ....., 19.....  
Where did injury occur? ..... (Specify city or town, county, and State)

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? No.  
If so, specify .....

(Signed) Dr. C. B. Shriver, D.O., M.D.  
(Address) Philadelphia, Mo.



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CERTIFICATE OF DEATH**

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**1. PLACE OF DEATH**

County Marion Registration District No. 55-1 File No. \_\_\_\_\_  
 Township Round Grove Primary Registration District No. 5-744 Registered No. 6  
 City \_\_\_\_\_ (No. \_\_\_\_\_) \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

George Washington Lindsey

(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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married (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.
	90	5	0	

OCCUPATION

8. Trade, profession, or particular kind of work done, as splanner, 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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19

19. UNDERTAKER (ADDRESS)

20. FILED 10, 28 - 1936 J. M. Crebs Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 27 1936

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

I last saw him 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:

Mitral Stenosis Date of onset \_\_\_\_\_  
Chronic interstitial Nephritis  
 Other contributory causes of importance: Uremia poisoning

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. G. C. Shriver M.D.

(Address) Philadelphia 200

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