

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.

Kermil # 62

OCT 22 1937

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

Do not use this space. *4*

34850

1. PLACE OF DEATH
 County *New Madrid* Registration District No. *5-5-1-266*
 Township *Anderson* Primary Registration District No. *F2-74* File No. _____
 City _____ (No. _____) St. _____ Registered No. *1274* Ward _____

2. FULL NAME *Thomas Jefferson Lincoln*
 (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 (write the word) *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Opal Lincoln*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan. 29 1884*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<i>52</i>	<i>8</i>	<i>7</i>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Farming*

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) *Bolinger Co. Mo.*

FATHER

13. NAME *Henry Lincoln*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Dont Know*

MOTHER

15. MAIDEN NAME *Dont Know*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Dont Know*

17. INFORMANT *Mrs. Opal Lincoln*
 (ADDRESS) *Hartsville Mo.*

18. BURIAL, CREMATION, OR REMOVAL
 PLACE *Rocky Fork* DATE *10-7* 1937

19. UNDERTAKER (ADDRESS) *W. H. ... Mo.*

20. FILED *Oct 10 1937* *M. O. ...*
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct 6* 1937

22. I HEREBY CERTIFY That I attended deceased from *Aug. 9* 1937, to *Sept. 29* 1937
 I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at *7 A.* m.
 The principal cause of death and related causes of importance were as follows:
Abscess of Lung
old tubercular abscess
stirred up after a case of
Typhoid
 Date of onset *8-9-37*

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) *K. Raymond Carlstrom, M. D.*
 (Address) *Malden, Missouri*

114B

CYCLE OF DEATH IN BIRTH TERMS? so that it is a de probetia. as a rule. EXCEPT AS STATED IN THE CONCLUSION OF THE REPORT.
THESE ARE THE RESULTS OF THE INVESTIGATION AND SHOULD BE CONSIDERED AS SUCH. ACE REPORT. I DO NOT KNOW THE NAME OF THE PERSON WHOSE NAME IS GIVEN IN THE REPORT.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

34850

Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 53
(b) Township Anderson Primary Registration District No. 6262 Registered No.
(c) City (d) Street No.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Thomas Jefferson Linedu
(a) Residence, No. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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.
52 8 7

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

9. Industry or business in which work was done, as 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. FUNERAL DIRECTOR (ADDRESS)

20. FILED Feb 10 1937 M. J. Murrell Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 6 1937

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

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:

Attacks of lung
all tubercular disease started
after a case of typhoid
fever 10 years ago.
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

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) Asa Gordon Carlstrom, DO (Address) Malden Mo

SUPPLEMENT

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. REGISTERARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

