

REC'D MAY 17 1938

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

Do not use this space.

14002

File No. 6

Registered No. 6

St. _____ Ward _____

1. PLACE OF DEATH

County Boone Registration District No. 74Township Rockyfork Primary Registration District No. 4042City Hallsville Mo (No. _____) St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. N. Palmer6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-13-18697. AGE YEARS 69 MONTHS 2 DAYS 1 If LESS than 1 day, _____ hrs. or _____ min.8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

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) Hinton Mo Boone (STATE OR COUNTRY)13. NAME James Tipton14. BIRTHPLACE (CITY OR TOWN) Hinton Mo Boone (STATE OR COUNTRY)15. MAIDEN NAME Rachel Stone16. BIRTHPLACE (CITY OR TOWN) Hinton Mo Boone (STATE OR COUNTRY)17. INFORMANT J. N. Palmer (ADDRESS) Hallsville Mo18. BURIAL, CREMATION, OR REMOVAL PLACE Centralia Mo DATE April 16 193819. UNDERTAKER Chandler & Mc Donald (ADDRESS) Hallsville Mo20. FILED 4-16-1938 - Mo. T. H. Faucet Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 14, 193822. I HEREBY CERTIFY, THAT I attended deceased from April 12, 1938 to April 14, 1938I last saw him alive on April 14, 1938. Death is saidto have occurred on the date stated above, at 3:00 p.m.

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

Intestinal Obstruction! Date of onset 4/12/3840

Other contributory causes of importance:

Name of operation none Date of _____What test confirmed diagnosis Phys Exam Was there an autopsy Yes

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

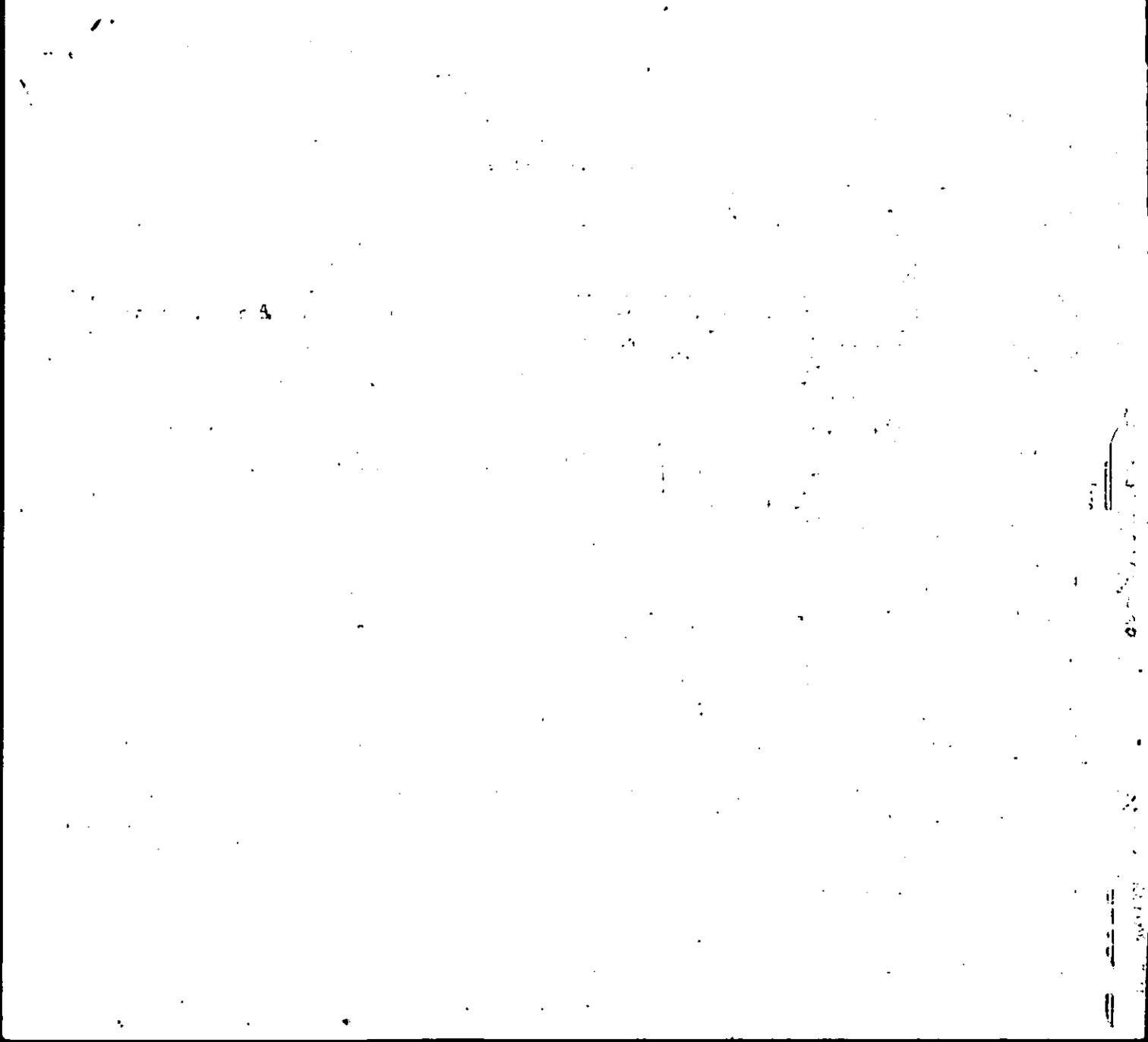
If so, specify _____

(Signed) T. M. Turner, M. D.(Address) Centralia Mo

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T. M. TURNER, M.D.

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.



FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

14002
Do not use this space.

1. PLACE OF DEATH

(a) County Boone Registration District No.
(b) Township Primary Registration District No. Registered No.
(c) City (d) Street No. St.
(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

(a) Residence, No. Elizabeth J. Palmer 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 F 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.
69 2 1

OCCUPATION
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)

FATHER
13. NAME

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

MOTHER
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 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 14, 1938

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

Intestinal obstruction Date of onset

Unknown probably

Other contributing causes of importance

My leg injury

Name of operation H&L 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) J. M. Jarner, M. D.

(Address) Centerville MO

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

SUPPLEMENTARY

