

REC'D MAY 25 1938

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

Do not use this space.

1. PLACE OF DEATH  
County Stoddard Registration District No. 836 File No. 16035  
Township Wester Primary Registration District No. 60989 Registered No. 21  
City Wester (No. 535 St. 21 Ward)

2. FULL NAME Thomas Anthony

(a) Residence, No. 535 St. 21 Ward. (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 OF RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF Delma Berke

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 3rd 1834

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
84 4 23

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

13. NAME S

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

15. MAIDEN NAME

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

17. INFORMANT Emma Anthony (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL  
PLACE Berke Mo. DATE Jan 12/1938

19. UNDERTAKER Hopkins Funeral Service (ADDRESS) Berke Mo.

20. FILED May 20 1938 Plourence Allen Registrar. 757 (Address)

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 26 1938

22. I HEREBY CERTIFY, that I attended deceased from April 10th, 1938, to April 26, 1938.  
I last saw him alive on April 26, 1938. Death is said to have occurred on the date stated above, at 2 P. m.  
The principal cause of death and related causes of importance were as follows:  
Stivily  
Date of onset 108

Other contributory causes of importance:  
Quinsinoid

Name of operation Cholec Date of /  
What test confirmed diagnosis? Cholec 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 /, 1938  
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) W. H. Allen M. D.

DO NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE CO.

MOTHER FATHER

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

16035-

**1. PLACE OF DEATH**

County Stoddard Registration District No. 836 File No. 21  
 Township Liberty Primary Registration District No. 6098a Registered No. \_\_\_\_\_  
 City Liberty (No. \_\_\_\_\_, St. \_\_\_\_\_, Ward \_\_\_\_\_)

**2. FULL NAME**

Thomas Anthony  
 (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**

**MEDICAL CERTIFICATE OF DEATH**

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 26 1938

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

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

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

I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
84 4 23

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

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as spinner, 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 \_\_\_\_\_

Date of onset \_\_\_\_\_  
 Other contributory causes of importance: \_\_\_\_\_

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

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

FATHER  
 13. NAME Want Know  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Want Know

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.

MOTHER  
 15. MAIDEN NAME Want Know  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS)

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_, 19\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_

19. UNDERTAKER (ADDRESS)

(Signed) W. H. Good, M. D.  
 (Address) Berlin

20. FILED 2-21 1939 Laura Hopkins  
 Registrar

Exact statement of OCCUPATION is very important. This in plain terms, so that it may be properly classified.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

1603J-  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Stoddard Registration District No. 803 6  
 (b) Township Liberty Primary Registration District No. 6098A Registered No. \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
 (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 Anthony  
 (a) Residence, No. \_\_\_\_\_ (Usual place of abode, if no street address, write county or city)  (If nonresident, give city or town and State)

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.  
84 4 23

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 \_\_\_\_\_

FATHER  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_  
 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 \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) \_\_\_\_\_, 19 \_\_\_\_\_

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 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:  
Sepsis  
 Date of onset \_\_\_\_\_

Other contributory causes of importance:  
Pneumonia  
Iber Pneumonia

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 W. H. Goad, M. D.  
 (Signed) \_\_\_\_\_ (Address) Berne Mo

SUPPLEMENTARY

Local Registrar.

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