

REC'D JUN 24 1938

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

Do not use this space.

19657

**1. PLACE OF DEATH**County ScottlandRegistration District No. 810Township JessaminePrimary Registration District No. 4488City Memphis (No. ....)

File No. ....

Registered No. 22

St. .... Ward)

**2. FULL NAME**

(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**Male**4. COLOR OR RACE**White**5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)**Married**21. DATE OF DEATH (MONTH, DAY, AND YEAR)** May 23, 1938**22. I HEREBY CERTIFY** That I attended deceased from Oct 1, 1936, to May 23, 1938I last saw him alive on May 23, 1938 Death is saidto have occurred on the date stated above, at 1245 m.

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

apoplexy

Date of onset

**5A. IS MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**Helen A. Hanes**6. DATE OF BIRTH (MONTH, DAY, AND YEAR)**June 30-1887**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, .... hrs. or .... min.

801023**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****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. UNDERTAKER (ADDRESS)****20. FILED**

19

Registrar.

Other contributory causes of importance:

Hypertension  
Paralytic agonia

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) E. E. Symmonds, M. D.(Address) Memphis Mo125

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**1. PLACE OF DEATH**

County..... Registration District No..... File No.....  
 Township..... Primary Registration District No..... -Registered No.....  
 City..... (No..... St..... Ward)

**2. FULL NAME**.....

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (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.
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	
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. UNDERTAKER (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 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:  
 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..... 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)..... (Signed)..... M. D.  
 (Address).....

Registrar.