

NOV 27 1938

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

35857

1. PLACE OF DEATH
 County Carroll Registration District No. 136 File No. _____
 Township De Witt Primary Registration District No. 5-194 Registered No. _____
 City De Witt (No. _____) St. _____ Ward _____

2. FULL NAME 216 died removed, Twin
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Black 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) Oct 16 - 38

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, <u>3</u> hrs. or <u> </u> min.
<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>✓</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work ✓
 (b) General nature of industry, business, or establishment in which employed (or employer) ✓
 (c) Name of employer ✓

9. BIRTHPLACE (CITY OR TOWN) De Witt Twp. Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER McBroadus

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Marion Mo.
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Neomie Cooper

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Marion Mo.
 (STATE OR COUNTRY)

14. INFORMANT (Address) McBroadus

15. FILED of 17, 1938 Alta Henderson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) _____ 19____

17. I HEREBY CERTIFY That I attended deceased on Oct 16 Oct 16, 1938, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pruritus Bili

CONTRIBUTORY (SECONDARY) 138 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED ✓
 IF NOT AT PLACE OF DEATH: _____
 DID AN OPERATION PRECEDE DEATH? ✓ DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS? no
 (Signed) H. G. Daniels, M. D.
Oct 17, 1938 (Address) De Witt Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL Oct 17 1938

20. UNDERTAKER Family ADDRESS McBroadus De Witt Mo.

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

1. PLACE OF DEATH

County..... Registration District No..... File No..... (n)
 Township..... Primary Registration District No..... Registered No..... (d)
 City..... (No.....) St..... Ward..... (c)
 (e)

2. FULL NAME.....

(a) Residence, No..... St., Ward..... P. R. S.
 (Usual place of abode) (If nonresident give city or town and State) (a)
 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.
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8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

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

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
 (STATE OR COUNTRY)

14. INFORMANT
 (Address)

15. FILED..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19.....

17. I HEREBY CERTIFY, That I attended deceased from 19.....

that I last saw h..... alive on....., 19....., to....., 19....., and that death occurred, on the date stated above, at..... m. A. D. 19.....

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., 19..... (Address).....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL, 19.....

20. UNDERTAKER ADDRESS 19.....

RECEIVED
 Health Officer No. 8
 Filed
 File Number
 11/13

NOTARY PUBLIC

NOTARY PUBLIC