

MO'G' DEC 19 1938

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

Do not use this space.

1. PLACE OF DEATH

County

Township

City

Registration District No.

Primary Registration District No.

(No.)

St.

Ward)

2. FULL NAME

(a) Residence, No.

(Usual place of abode)

St.

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

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)

MOTHER FATHER

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. UNDERTAKER (ADDRESS)

20. FILED

Date

1938

Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from

I last saw her alive on Nov 22, 1938. Death is saidto have occurred on the date stated above, at 6:00 p.m.
The principal cause of death and related causes of importance were as follows:Subar Pneumonia
Date of onset 8 days

Other contributory causes of importance:

Name of operation

Date of

What test confirmed diagnosis? Subar pneumonia Was there an autopsy? no

23. If death was due to external causes (violence), list in also the following:

Accident, suicide, or homicide? no Date of injuryWhere did injury occur? no (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)

(Address)

N. B.—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.

Mr Jones

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

40660
Do not use this space.

1. PLACE OF DEATH
(a) County Worth Registration District No. 205
(b) Township Allen Primary Registration District No. 6216 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 Amanda L Jones
(a) Residence, No. _____ St. [] (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
7. AGE YEARS 75 MONTHS 9 DAYS 8 If LESS than 1 day, _____ hrs. or _____ min.
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) Gentry Co (STATE OR COUNTRY) _____
13. NAME Samuel Colvin
14. BIRTHPLACE (CITY OR TOWN) Indiana (STATE OR COUNTRY) _____
15. MAIDEN NAME Elizabeth Adams
16. BIRTHPLACE (CITY OR TOWN) Indiana (STATE OR COUNTRY) _____
17. INFORMANT (ADDRESS) [Signature]
18. BURIAL, CREMATION, OR REMOVAL PLACE Miller's yard DATE _____ 19
19. FUNERAL DIRECTOR (ADDRESS) _____
20. FILED May 2, 1929 A. L. Davis Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-22-1938
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:
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 P. G. Ross (Signed) _____, M. D.
(Address) Grant City Mo

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

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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40660
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1. PLACE OF DEATH

(a) County Wart Registration District No. 905
 (b) Township Allen Primary Registration District No. 6216 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

Amanda L. Jones
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov-22, 1938

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

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:

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
75 9 8

Date of onset

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. Nurse wife
 10. Date deceased last worked at this occupation (month and year) _____
 11. Total time (years) spent in this occupation _____

Other contributory causes of importance:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Geneseo, N.Y.

FATHER 13. NAME Samuel Calvin

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indigo, N.C.

MOTHER 15. MAIDEN NAME Elizabeth Adams

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

17. INFORMANT (ADDRESS) J.P. Broughton

18. BURIAL, CREMATION, OR REMOVAL PLACE Miller Cemetery DATE Nov-23, 1938

19. FUNERAL DIRECTOR (ADDRESS) Broughton Bros
Wrens

20. FILED Nov 11, 1940 A.L. Carter
Local Registrar.

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) P.J. Prosser, M. D.
 (Address) Geneseo, N.Y.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTERERS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.