

DEC'D FEB 15 1939

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

Do not use this space.

1. PLACE OF DEATH

County *New Madrid*Township *West*City *423 Care N Alton*Registration District No. *1133*Primary Registration District No. *5799A*File No. *3261*

Registered 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

F

4. COLOR OR RACE

*C*5. SINGLE, MARRIED, WIDOWED, OR
DIVORCED (write the word)*Divorced*5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF*Alton*

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

Dec 4 1869

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, ... hrs.
or min.*68**11**26*

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.*None*10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation12. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)*Tenn*

13. NAME

*Jack Hill*14. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)*Tenn*

15. MAIDEN NAME

*Louise Hill*16. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)*Tenn*17. INFORMANT
(ADDRESS)*Alton*

18. BURIAL, CREMATION, OR REMOVAL

PLACE

Home

DATE

*12/3 38*19. UNDERTAKER
(ADDRESS)*Wm. J. Jones*

20. FILED

11/30 38

Registrar.

MEDICAL CERTIFICATE OF DEATH

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

11/30 38

22. I HEREBY CERTIFY, That I attended deceased from

11/30

19.

8

to

11/30 38

19.

I last saw him alive on *11/30* 19 *28*. Death is saidto have occurred on the date stated above, at *11 A* m.

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

Date of onset

*Apoplexy**Followed by**Paralysis*

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

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. J. Jones

M. D.

(Address)

*Essex, Tenn**540*

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.

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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
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

3261

Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 1133
(b) Township West Primary Registration District No. 5799A
(c) City _____ (d) Street No. _____ 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.

Registered No. _____

2. PRINT FULL NAME

(a) Residence, No. _____ St. ☐ _____
(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 7 4. COLOR OR RACE C 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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.
68 11 26

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) _____

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.

19. FUNERAL DIRECTOR (ADDRESS) Knight

20. FILED 11/31 1938 Jas. D. Rochel Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-30, 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 _____

(Signed) W. J. Huff, M. D.

(Address) Essex Mo.

