

REC'D JUN 22 1939

 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.

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, .....hra. or .....min.

## 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)

## 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

May 19 39

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

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

19

## 17.

I HEREBY CERTIFY, That I attended deceased from

19

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:

 Still born  
 mother had 2x alb  
 + Syphilis?

(duration) .....yrs. 3 mos. ....ds.

## CONTRIBUTORY (SECONDARY)

(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?.....

## WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

M. D.

, 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.

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

## DATE OF BURIAL

## 20. UNDERTAKER

## 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.

19356

File No.

Registered No.

St.

Ward)

308 Stillborn

Can't say

7-5-38

Lurey Mo

Lloyd Reed Mo

Mo

Mrs Russell

Mo

Lloyd Reed

L. Lurey Mo

Merle Sparling

545

Burkhardt Cemetery 7-5-1938

me

RECEIVED

District Health Officer No. 6,

District File Number 6-6-39-1201

Date Filed JUN 8 1939