

JUL 20 1939

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

Do not use this space.

1. PLACE OF DEATH

County Iron Registration District No. 439
Township Greenburg Primary Registration District No. 4257
City Baring (No. 7) St. Ward

File No. 22472
Registered No. 31

2. FULL NAME

William T. Tisdale
(a) Residence, No. St. Ward
(Usual place of abode)

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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 9 - 1868

7. AGE YEARS 71 MONTHS 3 DAYS 15 IF LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Railroad
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Laborer
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation 1

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Leadville Colo

13. NAME James Tisdale

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

15. MAIDEN NAME unknown

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

17. INFORMANT (ADDRESS) Minnie B. Tisdale Baring Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Hurdland DATE June 26 1939

19. UNDERTAKER (ADDRESS) Perth Washburn

20. FILED June 26 1939 Mrs. C.M. Smith Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 24 1939

22. I HEREBY CERTIFY, That I attended deceased from April 1939, to June 24 1939

I last saw him alive on June 24 1939. Death is said

to have occurred on the date stated above, at 11:40 a.m.

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

Chronic Endocarditis
Aortic Valve
Infected Stomach
Pericardial Fibrositis

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) J. P. Schatz
395 (Address) Baring 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.

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

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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)
 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.
 (If nonresident, give city or town and State)

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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OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.....	11. Total time (years) spent in this occupation.....
	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).....	

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. District Health Officer No. 10..... Registrar.

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)....., M. D.
 (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.

District File Number 7-39-1321

Date Filed JUL 19 1939