

REC'D SEP 20 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

(No. _____)

Registration District No.

Primary Registration District No.

File No.

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

MEDICAL CERTIFICATE OF DEATH

3. SEX M	4. COLOR OR RACE W	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Matt Jovic				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 3 1858				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
81	5	28		

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 1 1939

22. I HEREBY CERTIFY That I attended deceased from June 29 1939 to July 1 1939

I first saw her alive on July 1 1939. Death is said to have occurred on the date stated above, at 9 a.m.

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

Chronic endocarditis

Arteritis

Date of onset

Other contributory causes of importance:

Old age
Arteritis

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

FATHER

MOTHER

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE

DATE

1939

19. UNDERTAKER (ADDRESS)

20. FILED

1939

Registrar.

Name of operation..... Date of.....

What test confirmed diagnosis? Physicist Was there an autopsy? No

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.....

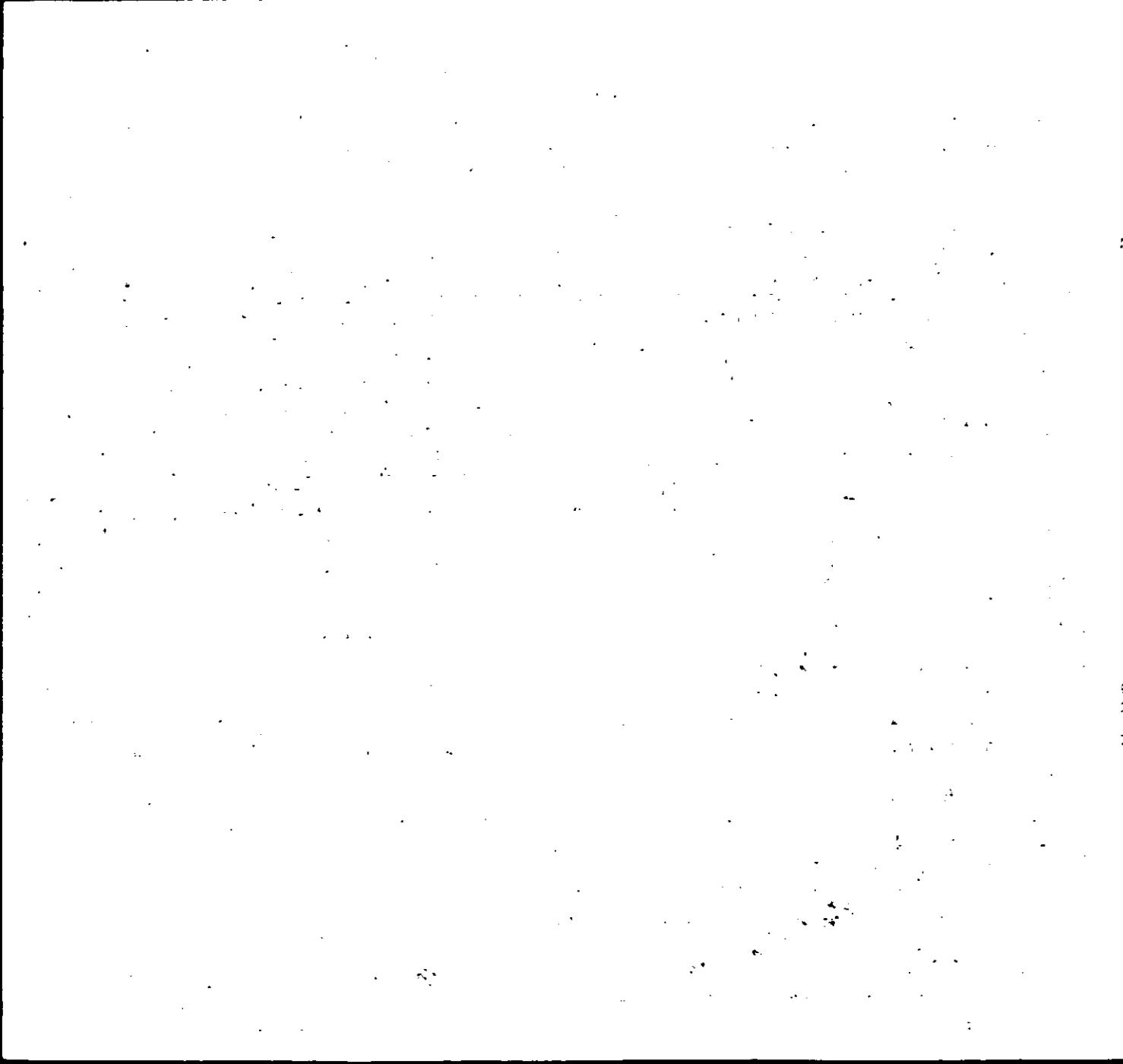
24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Charles J. Williamson M.D.

(Address) Gentry Mo

29118



FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

29118
Do not use this space.

1. PLACE OF DEATH
 (a) County Gentry Registration District No. 311
 (b) Township Boyle Primary Registration District No. 3430 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 Indiana Joes
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED W and

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

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

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>81</u>	<u>5</u>	<u>28</u>	

OCCUPATION

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) _____

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. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED Oct 3 1939 W. Williamson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-1-39

22. I HEREBY CERTIFY, That I attended deceased from _____ 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:

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) Chas. N. Williamson M. D.
 (Address) Gentry Mo.

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

S-29118