

NOV 4 1939
MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

35459

1. PLACE OF DEATH

County Hollinger

Registration District No. 69

Township Filmore

Primary Registration District No. 5165

City Grassy

(No. 1)

File No. _____
 Registered No. 7
 St. _____ Ward _____

2. FULL NAME William Maynard Rea

(a) Residence, No. Grassy, Mo. 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 Male 4. COLOR OR RACE White 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) April 28, 1926

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

13 10 11

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) Grassy, Mo. (STATE OR COUNTRY)

FATHER 13. NAME Joe Rea

14. BIRTHPLACE (CITY OR TOWN) Grassy, Mo. (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Effie Mitchel

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

17. INFORMANT Joe Rea (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL* PLACE Grassy, Mo. DATE March 11 1939

19. UNDERTAKER (ADDRESS)

20. FILED 11/18 1939 Mrs. Joe Rea Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 9th 1939

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 11:00 P. m.

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

Infantile 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 _____, 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) Andrew J. Baby, Colonel, M.D.

(Address) Petersville, Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

