

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

Do not use this space.

40224

1. PLACE OF DEATH

County Mason Registration District No. 547
 Township Mason Primary Registration District No. 3029
 City Hannibal (No. 610, N. 82) St. _____ Ward _____

File No. _____
 Registered No. 305

2. FULL NAME

W. Chester Lindsay
 (a) Residence, No. 620 N. 8th St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred 35 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Bebe Lindsay</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Oct 4-1863</u>				
7. AGE	YEARS <u>76</u>	MONTHS	DAYS <u>25</u>	IF LESS THAN 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Retired</u>			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>Railroad</u>			
	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) <u>Oake County, Mo</u>				
FATHER	13. NAME <u>Henry Lindsay</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kentucky</u>			
MOTHER	15. MAIDEN NAME <u>Unknown</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kentucky</u>			
17. INFORMANT <u>Mrs. W. C. Lindsay</u>				
18. BURIAL, CREMATION, OR REMOVAL <u>Bowling Green Mo</u> PLACE <u>Bowling Green Cemetery</u> DATE <u>Nov 7-1939</u>				
19. UNDERTAKER <u>Grace Bessehead</u> (ADDRESS) <u>Bowling Green Mo</u>				
20. FILED <u>Nov. 3 1939</u> <u>W. C. Lindsay</u>				

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-29 1939

22. I HEREBY CERTIFY, That I attended deceased from 10-29, 1939, to 10-29, 1939
 I last saw him alive on 10-29-39, 19____. Death is said to have occurred on the date stated above, at 2:30 A.m.
 The principal cause of death and related causes of importance were as follows:
Chronic nephritis Date of onset 2 years
 Other contributory causes of importance: uremia About 3 days

Name of operation Repair of urinary fistula
 What test confirmed diagnosis? _____ 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? _____
 If so, specify _____
 (Signed) Frederic B. Sedocis M. D.
 (Address) Hannibal, Mo.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE AND CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very importa

STATE OF MISSISSIPPI
RECORDS SECTION

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **40224**
REGRO

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
Registration District No. **547**

Primary Registration District No. **3029**

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ (Specify whether _____ years, months or days)

3. (a) PRINT FULL NAME William Clester Lindsay

3. (b) If veteran ## name war ##

3. (c) Social Security No. _____

4. Sex m 5. Color or race W

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>		<u>25</u>	hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) March 22 1939 (b) E. M. Suelle
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

20. DATE OF DEATH: Month Oct day 29
year 1939 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Howard B Goodrich (M. D. or other)
Address Hannibal Mo Date signed _____

SUPPLEMENTARY

MOTHER FATHER

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

