

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

Do not use this space.

26569

1. PLACE OF DEATH

County *Webster*

Registration District No. *901*

Township *W. Dallas*

Primary Registration District No. *6210*

City

(No. _____)

St. _____

Ward _____

2. FULL NAME

(a) Residence, (b) _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *75* 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 *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE, OF *Mary E. Weston*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Nov 13 1860*

7. AGE YEARS *79* MONTHS *7* DAYS *14* If LESS than 1 day, _____ hrs. or _____ min.

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. *Farmer* 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) *Douglas Co., Mo.*

FATHER 13. NAME *Solbert McDonald*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

MOTHER 15. MAIDEN NAME *Milly Miller*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Indiana*

17. INFORMANT (ADDRESS) *Mrs. Aaron Stroud*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Stewart Cemetery* *6-29 1940*

19. UNDERTAKER (ADDRESS) *Kelly Ferris*

20. FILED *7-29-1940* *J. C. Basso*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *6-27 1940*

22. I HEREBY CERTIFY, that I attended deceased from *Mar 29 1940* to *June 27 1940*

I last saw him alive on: *June 26 1940* Death is said to have occurred on the date stated above, at *3:15 P.M.*

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

Hemiplegia Paralysis 3-29-40 from senile debility. Sudden loss of voice. Loss of function of arm and limb. No pain, his mind was clear up to the last.

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. W. Wade, M.D.*

(Address) *Rogersville, 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.

RECEIVED

District Health Officer No. 6,

District File Number 840-2489

Date Filed AUG 19 1948