

FILED OCT 22 1940

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

Do not use this space.

33349

1. PLACE OF DEATH

County Boon
Township Shurrell
City _____ (No. _____)Registration District No. 568
Primary Registration District No. 6149File No. _____
Registered No. 27
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 m 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single - single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 19 19107. AGE YEARS MONTHS DAYS if LESS than 1 day,hrs. ormin.
2 21

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) (STATE OR COUNTRY) Licking MO13. NAME John Brown14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO15. MAIDEN NAME Bessie Green16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO17. INFORMANT John Brown (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL

PLACE Licking MO DATE 9-10 194019. UNDERTAKER (ADDRESS) W. L. Reed20. FILED 929 1940 W. L. Reed Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 9 194022. I HEREBY CERTIFY, That I attended deceased from June 19 1940, to Sept 9 1940. I last saw him alive on Sept 7 1940. Death is said to have occurred on the date stated above, at 8:30 a.m.

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

Premature Birth Date of onset _____Other contributory causes of importance: 159

Name of operation _____ Date of _____

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? noIf so, specify _____ (Signed) W. L. Reed M. D.(Address) Licking 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 5,

District File Number 10401047

Date Filed _____