

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.

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

37530  
Do not use this space.

FILED NOV 22 1944

1. PLACE OF DEATH

(a) County Dallas Registration District No. 97  
 (b) Township Wilson Primary Registration District No. 5-35-C Registered No. 53-  
 (c) City Loufane (d) Street No. \_\_\_\_\_ St.  
 (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 \_\_\_\_\_ mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME JOHN D. CHRISTIAN

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Married Elizabeth  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 23 1870  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
74 1 11  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
 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 \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-25-1944  
 22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 1942, to \_\_\_\_\_, 19\_\_\_\_  
 I last saw him alive on 10-24, 1944. Death is said to have occurred on the date stated above, at 2:00 p. m.  
 The principal cause of death and related causes of importance were as follows:

Uremia  
 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED  
 Date of onset 10-15-44  
 Other contributory causes of importance: Chr. arterio-sclerosis

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Loufane Mo

FATHER 13. NAME Marion Christian

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

MOTHER 15. MAIDEN NAME Margaret Beud

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) Mary McCreary

18. BURIAL, CREMATION OR REMOVAL PLACE Liberty DATE 10-25-1944  
Funeral Home

19. FUNERAL DIRECTOR (NAME) (ADDRESS) A. B. Jones  
Buffalo Mo

20. FILED Oct 30 1944 Mrs. A. L. Hoover  
 Local Registrar.

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? no  
 If so, specify \_\_\_\_\_  
 (Signed) Clara O. Johnson, M. D.  
 (Address) Buffalo Mo.



Registration District No. 17

Primary Registration District No. 5356

Registrar's No. 50

1. PLACE OF DEATH:

(a) County Dallas  
(b) City or town Wilson  
(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 years, months or days)

3. (a) PRINT FULL NAME

John D. Christians

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 nov 28 (Month) (Day) (Year)

8. AGE: Years 74 Months \_\_\_\_\_ Days \_\_\_\_\_ (Less than one day) \_\_\_\_\_ 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) \_\_\_\_\_ (b) \_\_\_\_\_ (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 Chronic hypotension } Duration \_\_\_\_\_

Due to 131 } \_\_\_\_\_

Other conditions Chr. arterio sclerosis (Include pregnancy within 3 months of death)

Major findings: CHRONIC HYPOTENSION PHYSICIAN \_\_\_\_\_  
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 W. O. J. Harmon (M. D. or other) M.D.  
Address Buffalo Mo Date signed 11-24-48

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

MOTHER FATHER

SUPPLEMENTARY

MAR 30 1948

37590