

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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County Jackson

Township _____

or

Village _____

or

City Waverly City

Registration District No. 99

File No. 402

Primary Registration District No. 002

Registered No. 134

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) Married

DATE OF BIRTH Oct 10 1890
(Month) (Day) (Year)

AGE 29 yrs. 9 mos. 2 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Home

BIRTHPLACE
(City or town, State or foreign country) Zalaki Ohio

PARENTS
NAME OF FATHER Milton Eason
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ohio
MAIDEN NAME OF MOTHER Caroline Prim
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Pa

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur O. Moody

(ADDRESS) 1638 A N. Prospect St.

Filed Jan 15 1910 W. S. Wheeler
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 12 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 12 1910, to Jan 12 1910, that I last saw him alive on Jan 12 1910, and that death occurred, on the date stated above, at ___ m.

THE CAUSE OF DEATH was as follows:
Capillary Bronchitis and Asthma
10 1/2
112 (Duration) 6 yrs. 0 mos. 0 ds.

Contributory (SECONDARY) _____ (Duration) ___ yrs. ___ mos. ___ ds.
(Signed) Wm. S. Thomas M. D.
Jan 12 1910 (Address) Waverly

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Elmwood DATE OF BURIAL Jan 1910
UNDERTAKER Geo. J. Stewart ADDRESS 1212 W. 9th

(If death occurred in a hospital or institution, give its NAME instead of street and number)

but under complete