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: Bollinger

Township: Lorance

or Village: ~~Glen Allen~~

or City: _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. 1826 File No. 18283

Primary Registration District No. 5105 Registered No. _____

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

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX: male

COLOR OR RACE: W

SINGLE / MARRIED / WIDOWED / OR DIVORCED (Write the word)

DATE OF BIRTH: March 20 (Month) (Day), 1915 (Year)

AGE: _____ yrs. 3 mos. 0 ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

BIRTHPLACE (City or town, State or foreign country): Bollinger C Mo

PARENTS

NAME OF FATHER: Buhren Rhodes

BIRTHPLACE OF FATHER (City or town, State or foreign country): Bollinger C Mo

MAIDEN NAME OF MOTHER: Mattie Upchurch

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Same

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Buhren Rhodes

(ADDRESS): Glen Allen Mo

Filed June 20, 191__ W W Davault, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: June 20 (Month) (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from June 15, 1915, to June 20, 1915, that I last saw him alive on June 19, 1915, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Hernia Scrotal
Hernia [illegible] reduced but
abscess followed, I think.

(Duration) _____ yrs. _____ mos. 5 ds.

Contributory (SECONDARY) ~~[illegible]~~

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W W Davault M. D.

8, 191__ (Address) Glen Allen Mo

*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: Glen Allen Mo

PLACE OF BURIAL OR REMOVAL: Glen Allen Mo

DATE OF BURIAL: June 22, 1915

UNDERTAKER: —

ADDRESS: _____

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

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____ (NO. _____, _____ St.; _____ Ward)

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

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

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day), *1*____ (Year)

AGE _____ yrs. _____ mos. _____ ds. | If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country) _____

PARENTS

NAME OF FATHER _____

BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day), *191*____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(SECONDARY)
_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*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	DATE OF BURIAL _____, 191____
UNDERTAKER	ADDRESS

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.