V. S. No. 2. A

MARGIN RESERVED FOR BINDING

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

1 PLACE OF DEATH

nty Shelby

nship Salt River

Registration District No. 830 File No. 19

ge ~~Shelb~~

Primary Registration District No. 6091 Registered No. 15219

~~Shelbina Mo~~ (NO. ..... St.; ..... Ward)

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

2 FULL NAME James Albert Quinn

PERSONAL AND STATISTICAL PARTICULARS

le	4 COLOR OR RACE White	5 SINGLE MARRIED + WIDOWED OR DIVORCED (Write the word) Married

E OF BIRTH November (Month) 14 (Day) 1865 (Year)

E 54 yrs. 3 mos. 19 ds. If LESS than 1 day, ... hrs. or ..... min.?

CUPATION Trade, profession, or ticular kind of work Retired farmer

General nature of industry iness, or establishment in ch employed (or employer)

THPLACE or town, or foreign country) Illinois

10 NAME OF FATHER James H Quinn

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Eaton Ohio

12 MAIDEN NAME OF MOTHER Mary Fall

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Eaton Ohio

HE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

nformant) H. G. Quinn

590 N. Broad St

(Address) Galesburg Ill.

led 3/31, 1920. Mittie Clay Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 3 (Month) (Day) 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from August, 1919, to March 3, 1920, that I last saw him alive on March 3, 1920, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

Ill.

54

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

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Furnish M. D.

3/3, 1920 (Address) Shelbina, Mo

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

18 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

19 PLACE OF BURIAL OR REMOVAL Toulon Ill DATE OF BURIAL 3/4, 1920

20 UNDERTAKER Ezra Peter ADDRESS Shelbina Mo

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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MISSOURI STATE BOARD OF HEA

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ..... St.; ..... Ward)

[If death occu hospital or in give its NAME of street and n

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day) 1 ..... (Year)

7 AGE ..... yrs. ..... mos. ..... ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

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

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

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ..... 191 ..... , ...

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day) , 191

17 I HEREBY CERTIFY, that I attended deceased

..... , 191 ..... , to ..... , 19

that I last saw h ..... alive on ..... , 19

and that death occurred, on the date stated above, at .....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. .....

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. .....

(Signed) .....

..... , 191 ..... (Address) .....

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. .....

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ..... , 19
20 UNDERTAKER	ADDRESS