LOCAL REGISTRAR'S RECORD—DO NOT TEAR

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

20121

1 PLACE OF DEATH

County Polk

Township South Benton Registration District No. 705 File No.

Primary Registration District No. 5934 Registered No. 8

Village

City (NO. St.; Ward)

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

2 FULL NAME William Mose Vest

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH (Month) (Day) 1852 (Year)

AGE 68 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

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

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

PARENTS

10 NAME OF FATHER unknown Vest

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

12 MAIDEN NAME OF MOTHER unknown

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Perry Gordon

(Address)

15 Filed May 10, 1920 A. W. Glover Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 6 (Month) (Day) 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from April 5, 1920, to May 6, 1920, that I last saw him alive on April 23, 1920, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

64

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. 4 mos. ds.

(Signed) D E Hammontree M. D.

May 7, 1920 (Address) Bolivar 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 Schofield Mo

DATE OF BURIAL 5/7, 1920

20 UNDERTAKER Newport Supply

ADDRESS Buffalo Mo

N. B. Every item of information should be carefully supplied. NOTE 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.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

N. B.—Every item of information should be carefully supplied. Particular attention to the CAUSE OF DEATH is very important. 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 HEAL
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 occurred hospital or institu give its NAME in of street and numb

2 FULL NAME Marlen

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

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..... (Ye

17 I HEREBY CERTIFY, that I attended deceased fr
....., 191....., to ....., 191....
that I last saw h..... alive on ....., 191....
and that death occurred, on the date stated above, at .....

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.

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

DATE OF BURIAL ....., 191.....

20 UNDERTAKER

ADDRESS