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

OCT 26 1927

Do not use this space.

27040

File No. ____

Registered No. 104

1. PLACE OF DEATH

County Henry — Registration District No. 347

Township Fields Creek — Primary Registration District No. 5490

City ____ (No. ____ St. ____ Ward)

2. FULL NAME Ruben Taylor ~~Lindsay~~ Lindsay

(a) Residence. No. ____ St. ____ Ward. ____

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*)
M	W	Married

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF Mrs R T Lindsay

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 2 - 1861

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ____hrs. or ____min.
	65	10	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

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

(c) Name of employer ____

9. BIRTHPLACE (CITY OR TOWN) Near Clinton

(STATE OR COUNTRY) Fields Creek Twp.

PARENTS

10. NAME OF FATHER Ruben T Lindsay

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ____

(STATE OR COUNTRY) North Carolina

12. MAIDEN NAME OF MOTHER Margaret Stone

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ____

(STATE OR COUNTRY) Dont Know

14. INFORMANT Mrs R T Lindsay

(Address) Clinton Mo

15. Filed Sept 19 1927 Dr E C Peeler Registrar

by DH

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-5- 1927

17. I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____, that I last saw h____ alive on ____, 19____, and that death occurred, on the date stated above, at ____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Was dead when I arrived. (probably heart disease)

9 CP (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY) ____ (duration) ____ yrs. ____ mos. ____ ds.

18. WHERE WAS DISEASE CONTRACTED ____

IF NOT AT PLACE OF DEATH? ____

DID AN OPERATION PRECEDE DEATH? ____ DATE OF ____

WAS THERE AN AUTOPSY? ____

WHAT TEST CONFIRMED DIAGNOSIS? ____

(Signed) H. E. Walton, M. D

9-6, 1927 (Address) Clinton Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Clinton Mo	9/6 1927
20. UNDERTAKER	ADDRESS
Sporeston	Clinton Mo

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Henry Registration District No. 347 File No.
Township Fields Creek Primary Registration District No. 5-490 Registered No. 104
City (No. St. Ward)

2. FULL NAME Ruben Taylor Lindsay
(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. Filed Sept 19 27 Dr. E C Peelor
REGISTRAR
by D.S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-5- 19 27

17. I HEREBY CERTIFY, That I attended deceased from ..., to ..., 19...
that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at ... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Was dead when I arrived
(Acute Heart Disease)
Don't Know.
CONTRIBUTORY (SECONDARY) Was dead when I arrived
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) , M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

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

SUPPLEMENTARY 2050

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

N. B.—Every item of information should be given. CAUSE OF DEATH in plain terms, so that it may be stated EXACTLY. PHYSICIANS should state AGE at statement of OCCUPATION is very important

PERMANENT RECORD