

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

Do not use this space.

✓ 422

FEB 20 1928

1. PLACE OF DEATH

County Carroll Registration District No. 135  
Township Carrollton Primary Registration District No. 3010  
City Carrollton Mo (No. ....) St. .... Ward (....)

2. FULL NAME Bluright Russell May

(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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Olivia E. Platz May

6. DATE OF BIRTH (MONTH, DAY AND YEAR)  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.  
42 | 9 | 4

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) Edwardsville Mich.  
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Jessie E. May

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mich.  
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Marilyn J. Bishop

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mich.  
(STATE OR COUNTRY)

14. INFORMANT Mrs D R May  
(Address) Carrollton Mo

15. FILED 1-16 1928 Mrs E E Farnham  
REGISTRAR

4 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-15 1928

17. I HEREBY CERTIFY, That I attended deceased from 12-13 to 1-15 1928 that I last saw him alive on 1-15 1928, and that death occurred, on the date stated above, at 5 A m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Typhoid fever  
12-30 (duration) yrs. mos. ds.  
129 (duration) yrs. mos. ds.  
CONTRIBUTORY acute perforation of small intestine (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

1 DID AN OPERATION PRECEDE DEATH? yes DATE OF 1/14/28

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? urinal

(Signed) H. B. Brown, M. D.

1-16 1928 (Address) Carrollton 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 Oak Hill Cem DATE OF BURIAL 1-16 1928

20. UNDERTAKER Standley ADDRESS Carrollton Mo

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of 2

SECRET  
to be destroyed

that it may be destroyed

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**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 Carroll Registration District No. 125 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 3010 Registered No. 5  
 City Carrollton (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Dwight Russell May

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4-11-1885

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
42 9 4

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_ (duration) yrs. mos. ds.  
 (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)

**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 1-16 1924 Mr. E. E. Farnham REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jun 15 1928

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:

CONTRIBUTORY \_\_\_\_\_ (duration) yrs. mos. ds.  
 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) \_\_\_\_\_, 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, or AGE should be fully classified. Exact OCCUPATION is vital. PHYSICIANS and REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

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