

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

Do not use this space.

1. PLACE OF DEATH

County.....
 Township.....
 City.....
 Registration District No. **791**
 Primary Registration District No. **1003**
 No. **410 N. Newstead** St. **Newstead**

File No. **42947**
 Registered No. **12220**
 St. Ward)

2. FULL NAME

(a) Residence. No. **410 N. Newstead** St. **19** 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 **Laura Herrickson**
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Nov 15, 1894**
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
54 0 29

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

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

10. NAME OF FATHER **George S. Herrickson**

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

12. MAIDEN NAME OF MOTHER **Gertrude Smith Egger**

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

14. INFORMANT (Name) (Address)
Mrs. Laura Herrickson
410 N. Newstead Ave

15. FILED **15 1928** **May E. Stanley** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **December 14 1928**
 17. I HEREBY CERTIFY, That I attended deceased from **11/15/28**, 19... to **12/14/28**, 19... that I last saw him alive on **12/14/28**, 19... and that death occurred, on the date stated above, at **9 P.** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

myocarditis - chronic
95c (duration) **1** yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **90B** (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTACTED
 IF NOT AT PLACE OF DEATH...

DID AN OPERATION PRECEDE DEATH? **no** DATE OF...

WAS THERE AN AUTOPSY? **yes**

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) **O. J. Falk**, M. D.

(Address) **Beaumont Kelly**
 *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
Tuscola Illinois Dec 16 1928

20. UNDERTAKER ADDRESS
Mullen Undertaking Co 5165 Belmont St

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.

