

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.

Wattwer

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

Do not use this space
43949 FEB 25 1929
File No. _____
Registered No. 1
St. _____ Ward)

1. PLACE OF DEATH

County *wright* Registration District No. *908*
Township *mountain cross* Primary Registration District No. *4579*
City *mountain cross*

2. FULL NAME

Ernest Eugene Proctor Massey

(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 *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug 14 - 28*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
0 4 16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *00*
(b) General nature of industry, business, or establishment in which employed (or employer) *0*
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *mountain cross*
(STATE OR COUNTRY) *Missouri*

10. NAME OF FATHER *John Proctor*

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

12. MAIDEN NAME OF MOTHER *Edis Massey*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Stover*
(STATE OR COUNTRY) *Missouri*

14. *Mrs Edis Massey*
(Address) *mountain cross*

15. Filed *1/30 29* 19*29* Registrar *[Signature]*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 9 1928*

17. I HEREBY CERTIFY, That I attended deceased from *Dec 9 1928* to *Dec 9 1928* that I last saw him alive on *Dec 9 1928*, and that death occurred, on the date stated above, at *9:15 p.m.*

THE CAUSE OF DEATH WAS AS FOLLOWS:

Branchial Pneumonia
9
187A

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH:

DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____
WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*
12/18 (Signed) *K. Massey* M. D.
1928 (Address) *Mountain Cross*

*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 *Cathern Cem* DATE OF BURIAL *Dec 11 1928*
20. UNDERTAKER *[Signature]* ADDRESS *[Signature]*

**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 Wright

Registration District No. 908

File No.

Township Wm. Grove

Primary Registration District No. 2349

Registered No. 1

2. FULL NAME Evert Eugene Croctor

(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 S
(write the word)

5A. NE 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)

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 1/30 1929 J. M. Lambord REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 9 1928

17. I HEREBY CERTIFY, That I attended deceased from to
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:
Bronchial pneumonia following Whooping Cough

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) 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

20. UNDERTAKER ADDRESS

19

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B.---Ex. of item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-43947-1