

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

Do not use this space.

6073

1. PLACE OF DEATH

County Franklin Registration District No. 901 File No. _____
 Township Prasie Primary Registration District No. 5418 Registered No. _____
 City _____ (No. _____) St. _____ (Ward _____)

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward. _____
 (Usual place of abode) Lebbony Mo
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.
 (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

| | | | | | |
|---|---|---|---|---|--|
| 3. SEX <u>Female</u> | | 4. COLOR OR RACE <u>White</u> | | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Infant</u> | |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <input checked="" type="checkbox"/> | | | | | |
| 6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>1/1</u> | | | | | |
| 7. AGE | YEARS <input checked="" type="checkbox"/> | MONTHS <input checked="" type="checkbox"/> | DAYS <input checked="" type="checkbox"/> | If LESS than 1 day, <u>20</u> hrs. or <u>—</u> min. | |
| 8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work... <u>Infant</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____ | | | | | |
| 9. BIRTHPLACE (CITY OR TOWN) <u>Lebbony Mo</u> (STATE OR COUNTRY) | | | | | |
| PARENTS | 10. NAME OF FATHER <u>Ed Woodcock</u> | | | | |
| | 11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Lebbony Mo</u> (STATE OR COUNTRY) | | | | |
| | 12. MAIDEN NAME OF MOTHER <u>Blanch Porter</u> | | | | |
| | 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Lebbony Mo</u> (STATE OR COUNTRY) | | | | |
| 14. INFORMANT <u>Ed Woodcock</u> (Address) <u>Lebbony Mo</u> | | | | | |
| 15. FILED <u>3/11 1929</u> <u>L.P. Dewhirst M.D.</u> REGISTRAR | | | | | |

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb-25 1929

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 _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Renutrition Infant
159

CONTRIBUTORY 16/10
 (SECONDARY) (duration) _____ yrs. _____ mos. _____ da.

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) W. H. Dewhirst, M. D.
 , 19____ (Address) Lebbony 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 Woodcock Cemetery DATE OF BURIAL 2/25 1929

20. UNDERTAKER None ADDRESS _____

X. 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. MAR 21 1929

