MAY 27 1930

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

Do not use this space.

13224

1. PLACE OF DEATH
County Linn. Registration District No. 196 File No.
Township Primary Registration District No. 8025 Registered No. 29
City Brookfield (No. St. Ward)

2. FULL NAME Virgil Post
(a) Residence. No. 113 Green St., 2 Ward. (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 32 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 White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 17 1857

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ... min.
73	3	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Railroad employee
(b) General nature of industry, business, or establishment in which employed (or employer) Helper, mechanics
(c) Name of employer C.B. & Q. R.R.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Chariton County Mo

PARENTS
10. NAME OF FATHER Alverson Post
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Chariton County
12. MAIDEN NAME OF MOTHER Jane Don't know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14. INFORMANT Mrs Pauline Shaw
(Address) 10 Penn Ave

15. FILED April 4, 1930 Thos P. Fore REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 2 1930

17. I HEREBY CERTIFY, That I attended deceased from March 29, 1930, to April 2, 1930, that I last saw him alive on April 2, 1930, and that death occurred, on the date stated above, at 2 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar pneumonia
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (SECONDARY) Interstitial nephritis
Don't know (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Same
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Usual Clinical
(Signed) C. C. Enosh D.O., M. D.
4-3, 1930 (Address) Brookfield 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 Rose Hill Cemetery
DATE OF BURIAL 4-4 1930

20. UNDERTAKER Homer S Bowden
ADDRESS Brookfield

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should [illegible] 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 Linn — Registration District No. 496 — File No.

Township — Primary Registration District No. 3022 — Registered No.

City Brookfield (No. ..... St. ..... Ward)

2. FULL NAME Virgil Post

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)

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) Dec 17-1856.

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
X	73X	3	15	

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 Apr. 4, 1930. Dr. T. P. Fox REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 2 1930

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:

.....

.....

.....

..... (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) ....., 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

SUPPLEMENTARY

WRITE PLAINLY, WITH UNFADING INK

N. B.—Every item of information should be carefully supplied. A [illegible] 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.

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

S-13224