

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

Do not use this space.

15941

**1. PLACE OF DEATH**

County Howell Registration District No. 384  
Township \_\_\_\_\_ Primary Registration District No. 4227  
City West Plains, Mo (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. 5-5-  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(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.

W J Causey

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX ma 4. COLOR OR RACE wht 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Francis Causey

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 17-1880

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>80</u>	<u>1</u>	<u>8</u>	

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work. Farmer  
(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) Tennessee

PARENTS	10. NAME OF FATHER	<u>Causey</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)	<u>Tenn</u>
	12. MAIDEN NAME OF MOTHER	<u>Mary</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)	<u>Tenn</u>

14. INFORMANT (Address) Mrs Jett Brown West Plains Mo

15. FILED 26-30 1930 Opa Heinrichs REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/25-1930

17. I HEREBY CERTIFY, That I attended deceased from May 18, 1930 to May 25, 1930 that I last saw him alive on May 30, 1930 and that death occurred, on the date stated above, at 3:30 p. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Uremia  
132B  
1162 (duration) 4 yrs. 4 mos. 4 ds.  
CONTRIBUTORY (SECONDARY) Accidents  
(duration) 5 yrs. 4 mos. 4 ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) P. J. [Signature] M. D.

of 26, 1930 (Address) West Plains 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 Yalloway DATE OF BURIAL 5/27 1930

20. UNDERTAKER McFarland's ADDRESS West Plains Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be stated EXACTLY.

JUN 5 1930

1930-8-28  
 80-4-17  
 -----  
 1850-1-08

**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 Howell  
Township .....  
City West Plains

Registration District No. 384  
Primary Registration District No. 4227

File No. ....  
Registered No. 93-  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. .... St. .... Ward. ....  
(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. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

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

5A. IF 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 5-26-30 O.M. Hinrich REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 25 1930

17. I HEREBY CERTIFY, That I attended deceased from .....  
to ..... 19....., 19.....  
that I last saw h..... at ..... on .....  
death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Septicemia  
cause unknown  
.....  
(duration) ..... yrs. .... mos. .... ds.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH DATE OF 12/9/29

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

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

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.

SUPPLEMENTARY

S-15941