

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

Do not use this space.

31833

1. PLACE OF DEATH

County Macon
Township Beaumont
City Waverly (No. _____)

Registration District No. 964
Primary Registration District No. 3710

File No. 5
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. Waverly 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) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1851 Aug 1

7. AGE YEARS 82 MONTHS 1 DAYS 24 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

13. NAME Peter Minquis

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Leopold

15. MAIDEN NAME Elizabeth Barr

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn

17. INFORMANT Mrs. D. B. Lee (ADDRESS) Leopold

18. BURIAL, CREMATION, OR REMOVAL PLACE Bellevue DATE Sept 26, 1931

19. UNDERTAKER W. H. McCollum (ADDRESS) Waverly

20. FILED Sept 25, 1931 Registrar W. H. McCollum

2. MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 24, 1931

22. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1931, to Sept 24, 1931, last saw h. em. alive on Sept 24, 1931. Death is said to have occurred on the date stated above, at _____, m.

The principal cause of death and related causes of importance were as follows:

Chronic Nephritis
Acute Prostatitis

Other contributory causes of importance: _____

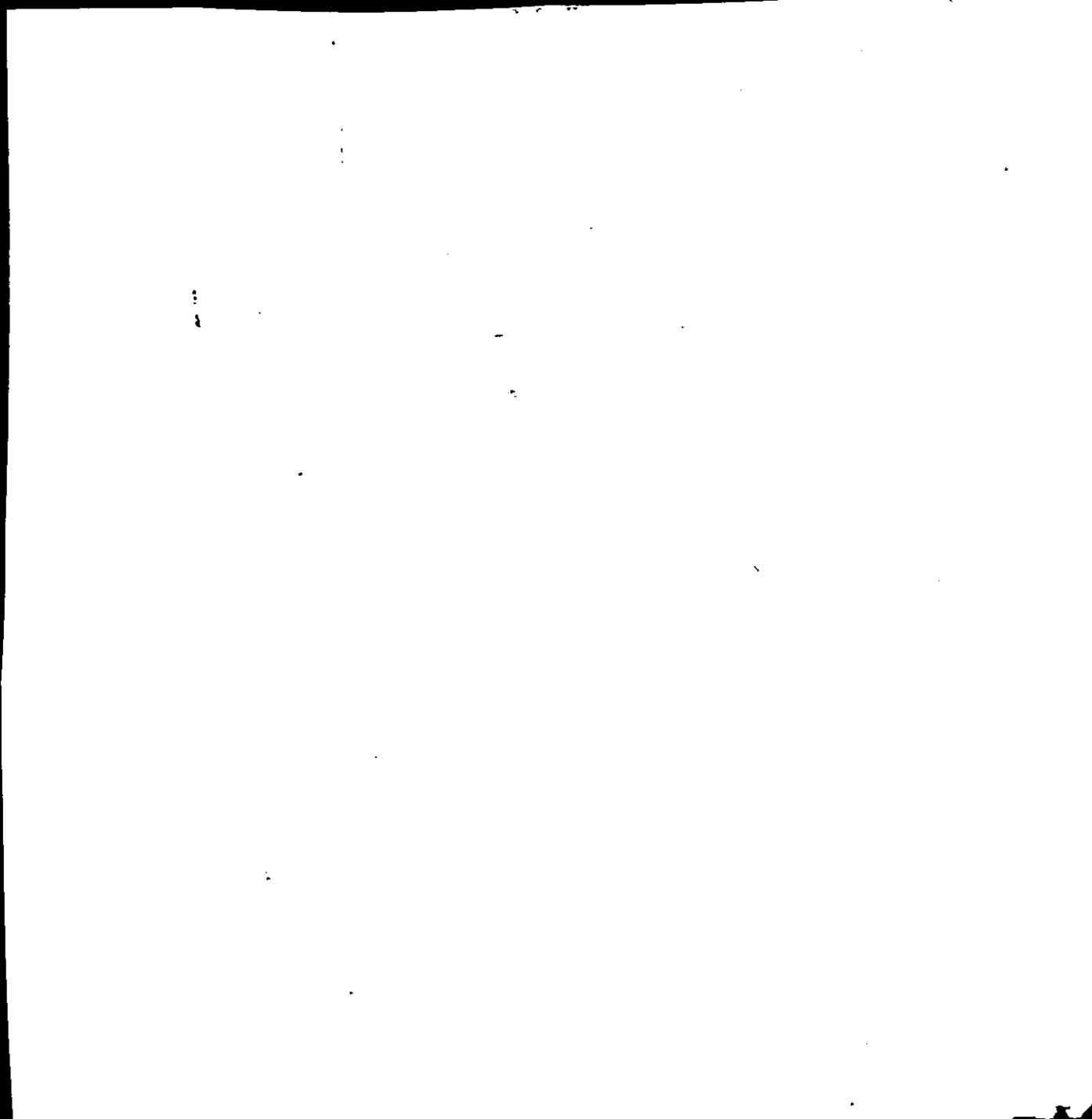
Name of operation _____ Date of _____
What test confirmed diagnosis? Culture Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____ (Signed) J. H. McCollum, M. D.
(Address) Waverly Mo



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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Macon Registration District No. 964 File No. _____
 Township Darke Primary Registration District No. 2-700 Registered No. 3-
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

W. A. Mingus

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Abel R. Mingus July 30 1849

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 1 - 1857

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
X 82 X | 1 | X 24 X

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. Files Sept 25 19 31 J. W. H. H. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9 / 24 19 31

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

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

REGISTRARS SHALL NOT RECEIVE A TELEPHONE ORDER FOR DEATH CERTIFICATE

S-31833