

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

Do not use this space.

33786

1. PLACE OF DEATH

County Calaway
Township Calaway
City (No. St. Ward)

Registration District No. 108
Primary Registration District No. 3137

File No.
Registered No.

2. FULL NAME

Floyd Granville Dees

(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) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Susan J. Dees

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 25, 1852

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 10 6

OCCUPATION 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) Lynchburg Virginia

MOTHER FATHER 13. NAME Ezekiel Dees

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

MOTHER 15. MAIDEN NAME W K

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) W K

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Unity Church DATE Nov 2 1931

19. UNDERTAKER (ADDRESS)

20. FILED Mr 2 1931 R. S. Sincere Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 31 1931

22. I HEREBY CERTIFY, That I attended deceased from Oct 28 1931 to Oct 31 1931
I last saw him live on Oct 31 1931 Death is said to have occurred on the date stated above, at 1p m.
The principal cause of death and related causes of importance were as follows:

Date of onset

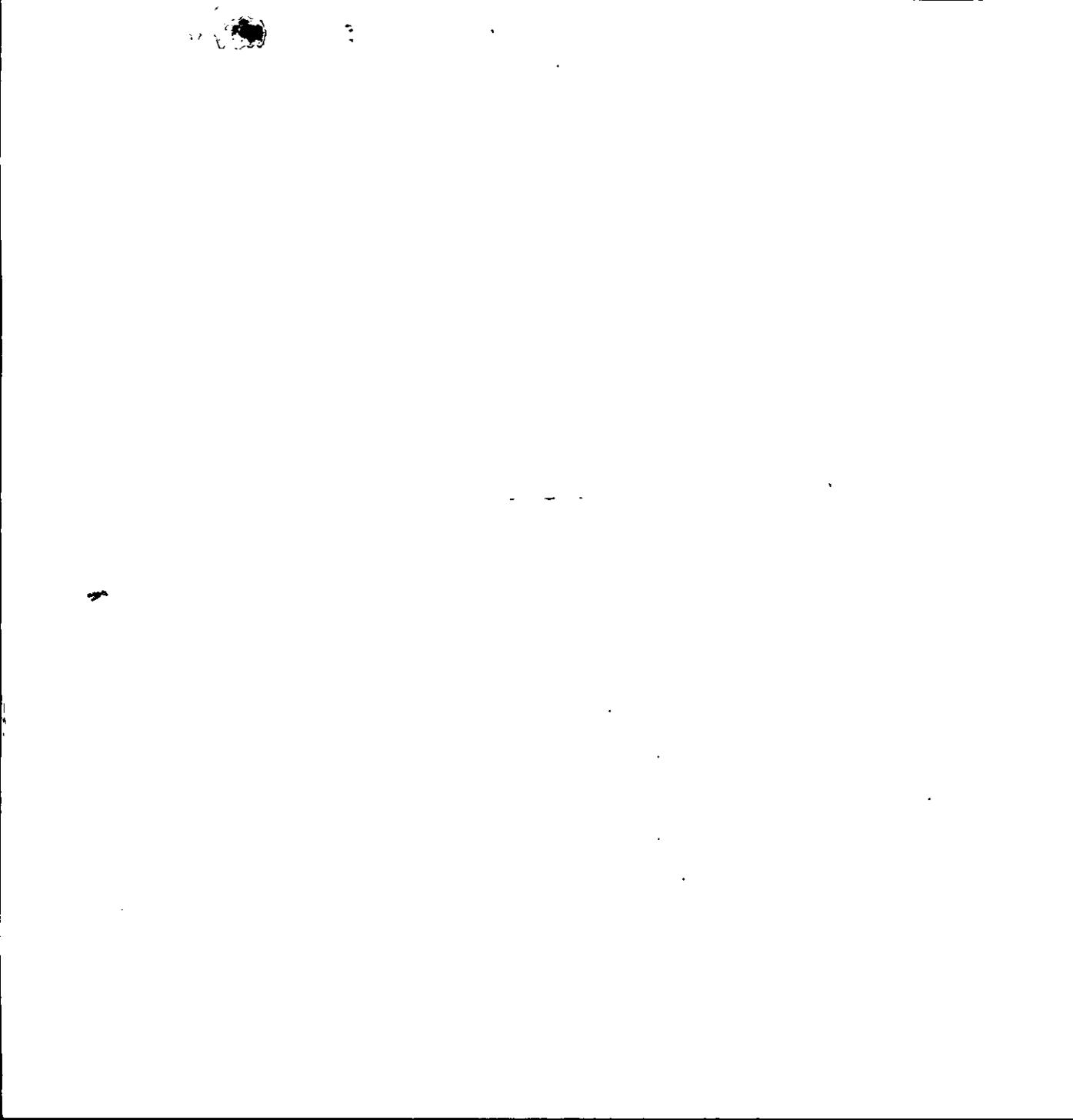
Other contributory causes of importance:
analyses 4 yrs

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

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?
If so, specify
(Signed) R. S. Sincere M. D.
(Address) Fulton Mo



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

33786.

1. PLACE OF DEATH

County Callaway Registration District No. 108 File No.
 Township Callaway Primary Registration District No. 5157 Registered No.
 City (No.) St. Ward

2. FULL NAME

Floyd Granville Lewis
 (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 (write the word) M.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 25 1852

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
78 | 10 | 6

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. Nov 21 1931 R. S. Lince
 FILED REGISTER

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 31 1931

17. I HEREBY CERTIFY That I attended deceased from 19..... 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:
1 Paralysis
Hemi
right side
 (duration) 4 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

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

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

S-33786