

DEC 20 1935

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

Do not use this space.

40547

1. PLACE OF DEATH
 County Franklin Registration District No. 655
 Township Steel Mo Primary Registration District No. 4392
 City Steel Mo (No. 10) St. Peacock Ward 10
 2. FULL NAME Louise 10 Peacock
 (a) Residence, No. 10 St. Peacock Ward 10
 (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) Wid

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-5-1932

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>3</u>	<u>10</u>		

OCCUPATION

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

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) Steel Mo (STATE OR COUNTRY) _____

MOTHER

13. NAME Albert Peacock

14. BIRTHPLACE (CITY OR TOWN) Parsons Tenn (STATE OR COUNTRY) _____

15. MAIDEN NAME Ethel Crews

16. BIRTHPLACE (CITY OR TOWN) Parsons Tenn (STATE OR COUNTRY) _____

17. INFORMANT Albert Peacock (ADDRESS) Steel Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE No 9 Oak DATE 12-6-35

19. UNDERTAKER (ADDRESS) _____

20. FILED 12/10/35 1935 Wm. H. Kelly Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-5-1935

22. I HEREBY CERTIFY, That I attended deceased from 12-5-1935, 1935, to 12-5-1935, 1935. I last saw him alive on 12-5-1935. Death is said to have occurred on the date stated above, at 6:30 am. The principal cause of death and related causes of importance were as follows: Loxall Baneff. Date of onset _____

Other contributory causes of importance: Convulsions

Name of operation _____ Date of operation _____

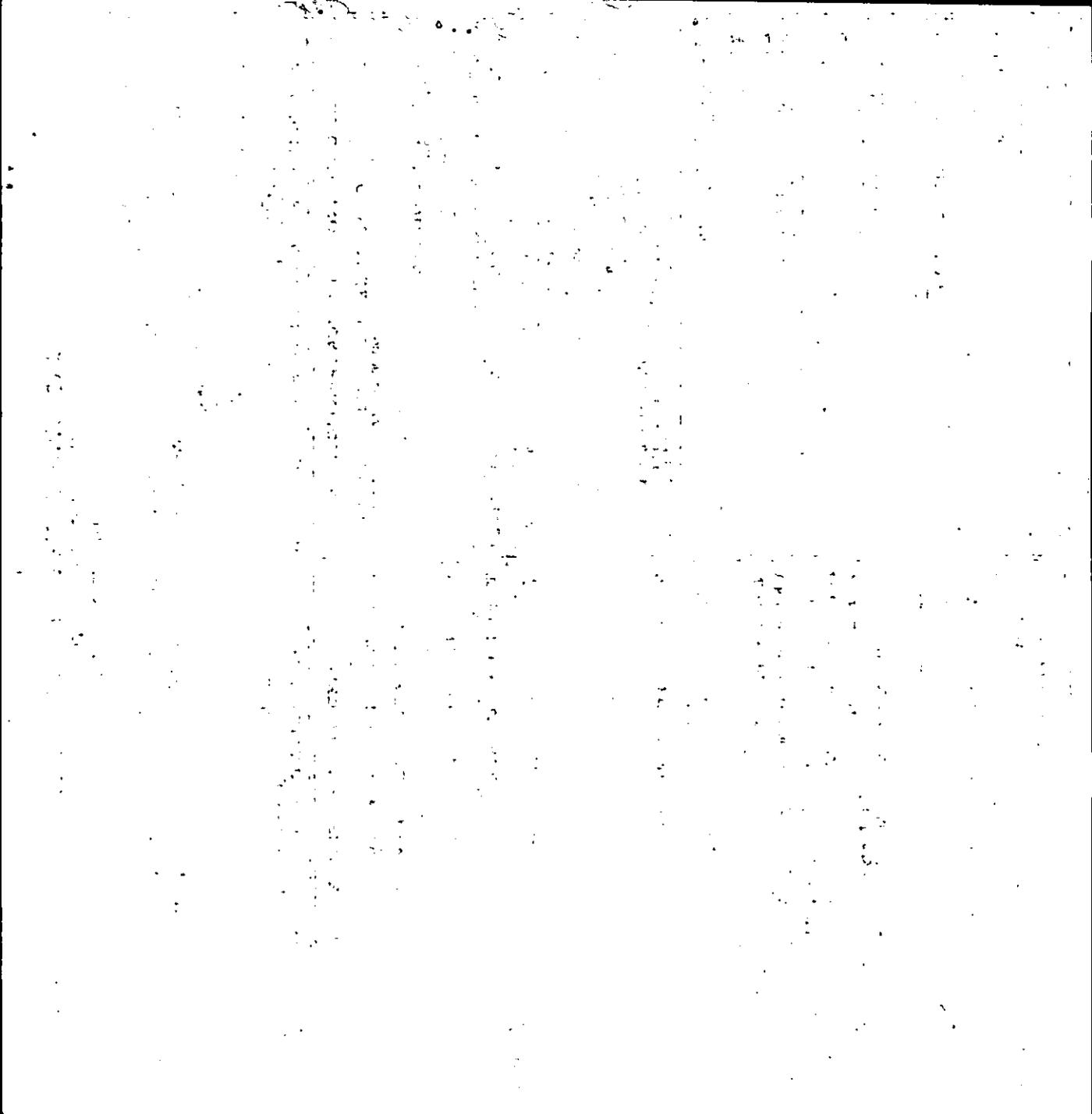
What test confirmed diagnosis Physical Examination there of _____

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) J. W. Robbins, M. D. (Address) Steel Mo



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

Do not use this space.

1. PLACE OF DEATH

County Pemiscot Registration District No. 685 File No. _____
 Township _____ Primary Registration District No. 4372 Registered No. _____
 City Steele, Mo. (No. _____) St. _____ Ward _____

2. FULL NAME Lonnie D. Peacock

(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 mf
(write the word)

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

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

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs; or min.
	3	10		

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

FATHER
 13. NAME _____

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

MOTHER
 15. MAIDEN NAME _____

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____, 19__

19. UNDERTAKER (ADDRESS)

20. FILED _____, 19__ Max H. Kelly Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12 - 5 - 1931

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw him/her alive on _____, 19____. 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:

Enlarged Bowels
Acute Catarrh
 Other contributory causes of importance: Constipation

Name of operation _____ Date _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence, etc.) 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) J. H. Robbins M. D.
 (Address) Steele Mo

5-40547