

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

Do not use this space.

23789

JUL 25 1936

1. PLACE OF DEATH
 County Lemhi Registration District No. 15314
 Township Conard Primary Registration District No. 5869
 City Portageville (No. 1) St. 16 Ward

2. FULL NAME George H Cottrell
 (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) Child

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 8 1934

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>2</u>	<u>4</u>	<u>17</u>	

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) Portageville

13. NAME Cecil L Cottrell

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

15. MAIDEN NAME Marie Wheeler

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

17. INFORMANT Cecil L. Cottrell (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE Portageville DATE June 26, 1936

19. UNDERTAKER (ADDRESS) Wm. W. Cook

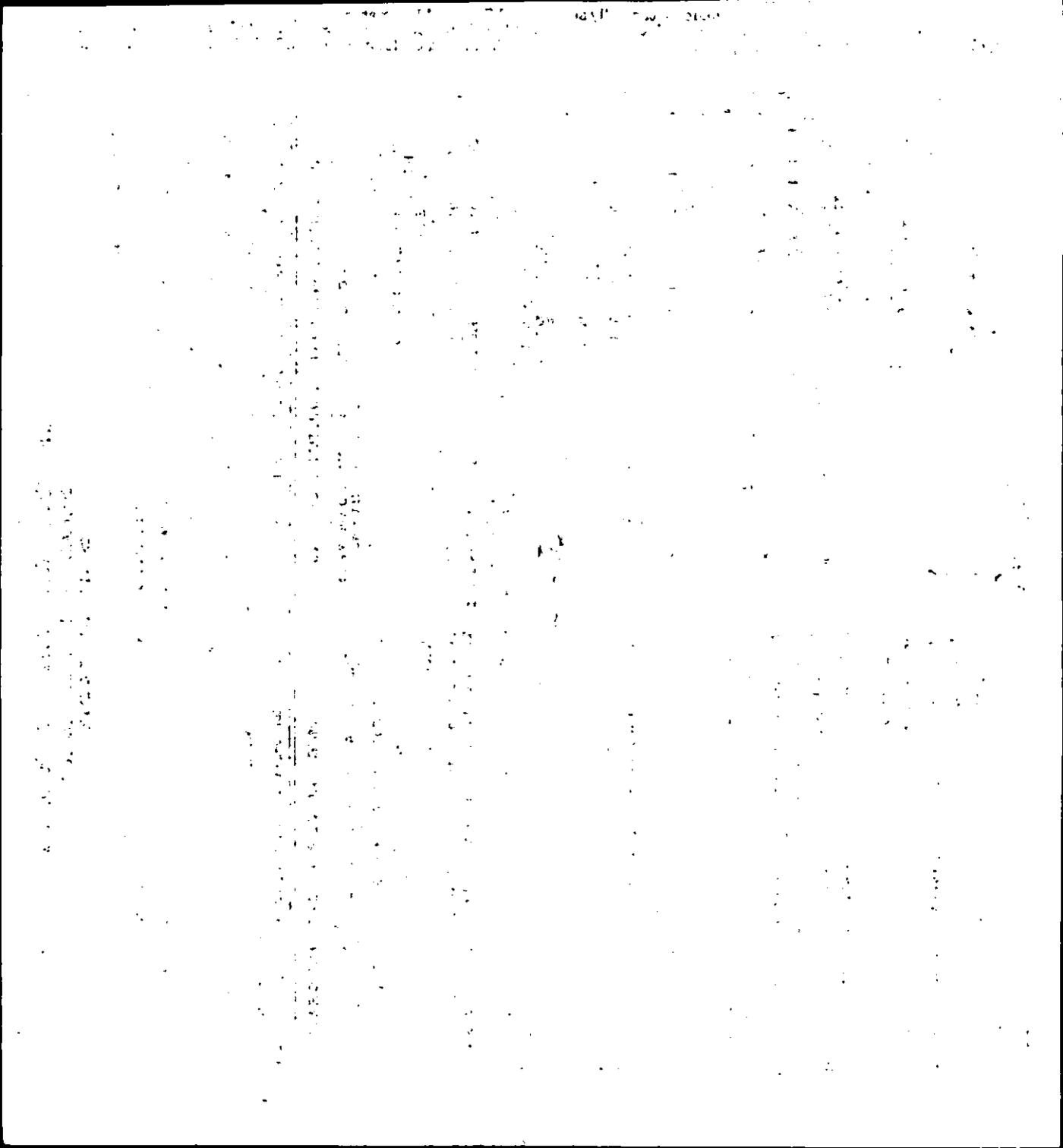
20. FILED 7-10 19 36 May W. Cook Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 25 1936

22. I HEREBY CERTIFY That I attended deceased from June 22, 1936, to June 25, 1936
 I last saw him alive on June 23, 1936. Death is said to have occurred on the date stated above, at 3:30 p.m.
 The principal cause of death and related causes of importance were as follows:
Infectious Diarrhea
 Other contributory causes of importance: Upper Respiratory Inf.
 Name of operation Date of
 What test confirmed diagnosis? 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) John Killian M. D.
 (Address) Portageville, Mo.

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.



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1. PLACE OF DEATH .

County Demarest
Township Concord
City (No. _____) _____

Registration District No. 653
Primary Registration District No. 3865

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

2. FULL NAME

Geo W. Cattrell

(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) child

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 day, yrs. or min.
2 4 17

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 8-10, 1936 Just Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-20, 1936

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

Last saw h. _____ 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:

Infectious Diarrhea Date of onset _____

Other contributory causes of importance:
upper respiratory infect
acute influenza

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 John F. Killian, M. D.
(Signed) Paragville, Mo.
(Address)

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.

SUPPLEMENT

S-23789