

REC'D FEB 23 1939

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

Do not use this space.

1. PLACE OF DEATH

35 County SturgeonTownship LehighCity Revere, Mo.452Registration District No. 288Primary Registration District No. 5406File No. 2184

Registered No. _____

St. _____

Ward _____

2. FULL NAME

(a) Residence, No. _____

(Usual place of abode)

St. _____ Ward _____

(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 M4. COLOR OR RACE Col

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) _____

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.

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) Revere, Mo.13. NAME John Williams14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri15. MAIDEN NAME Becky Leaf16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Revere17. INFORMANT (ADDRESS) John Williams

18. BURIAL, CREMATION, OR REMOVAL

PLACE at home DATE 1-15 193919. UNDERTAKER (ADDRESS) Family20. FILED 2-1- 1939 Thurman

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-14 1939

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

I last saw h. attended by physician 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:

Date of onset _____

Other contributory causes of importance: _____

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) Thurman, M. D.(Address) Revere, Mo.

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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.

RECEIVED

District Health Officer No. 3,

District File Number 39-144

Date Filed 9-8-39