

REC'D MAR 8

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

Do not use this space.

6691

1. PLACE OF DEATH

County *Dallas Co*
Township *Willow Springs*
City *Willow Springs, Mo*

Registration District No. *862*

Minor Registration District No. *6224*

File No. _____

Registered No. _____

St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. *1* 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 *female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *U R Coffey*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 29, 1859*

7. AGE YEARS MONTHS DAYS If LESS than day, hrs. or min. *79 0 29*

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. *House wife*

10. Data 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) *FRANKLIN CO MO*

13. NAME *U R Coffey*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Suba Co Mo*

15. MAIDEN NAME *Sherry C Stone*

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

17. INFORMANT *Sherry Coffey* (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE *Cave Creek* DATE *2-27-1939*

19. UNDERTAKER *J R Roney* (ADDRESS) *Willow Springs, Mo*

20. FILED _____ 19 _____ Registrar _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *2-25-1939*

22. I HEREBY CERTIFY, That I attended deceased from *from Jan 31, 1939 to Feb 20, 1939*

I last saw him 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 _____

Tuberculous disease
Other contributory causes of importance: *1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20.*

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) *J R Roney*, M. D.

759 (Address) _____

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

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1. PLACE OF DEATH

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

2. FULL NAME.....

(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	4. COLOR OR RACE	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)				
MOTHER / FATHER	13. NAME			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
	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..... Registrar				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) , 19.....

22. I HEREBY CERTIFY, That I attended deceased from 19....., to..... 19.....
 I 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:
 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)....., M. D.
 (Address).....

N. B.—Every item of information furnished is carefully supplied. AGE should be stated EXACTLY. If a GOVERNMENT EMPLOYEE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

6691
Do not use this space.

1. PLACE OF DEATH
(a) County Howell Registration District No. 862
(b) Township Howell Primary Registration District No. 385
(c) City Howell (d) Street No. 6229 Registered No. 96
(e) Length of residence in city or town where death occurred 1-13 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME Lucinda C. Pierce
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widow
5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF Mrs Pierce
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7-27-1899
7. AGE YEARS 79 MONTHS 6 DAYS 29 If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-25-1939
22. I HEREBY CERTIFY, That I attended deceased from 1-15-1939 to Feb 20 1939
I 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:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Yellow Springs mo
13. NAME Lucinda
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Howell mo
15. MAIDEN NAME Sarah C. Thomas
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dun mo

Other contributory causes of importance: Cholera
Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

17. INFORMANT (ADDRESS)
18. BURIAL, CREMATION, OR REMOVAL PLACE Pine Creek DATE 2-27-1939

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

19. FUNERAL DIRECTOR (ADDRESS) J. R. Rieger
Yellow Springs mo
20. FILED ap 24 1939 Mrs. Clois Cunningham Local Registrar

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) S. E. Hagercraft, M. D.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. CAUSE OF DEATH IN plain terms, so that it may be properly classified. If necessary, state OCCUPATION is very important.

SUPPLEMENTED

