

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

Do not use this space.

REC'D OCT 12 1939

1. PLACE OF DEATH

County CHRISTIAN

Registration District No. 186

Township GARRISON

Primary Registration District No. 5262A

City 6577

(No. _____ St. _____ Ward)

File No. 32155

Registered No. _____

2. FULL NAME UNNAMED

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

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

MALE

White

SINGLE

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 28th '39

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. 30

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) CHRISTIAN

13. NAME JACK Prime

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

15. MAIDEN NAME Troy ESSARY

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

17. INFORMANT H. J. ESSARY

18. BURIAL, CREMATION, OR REMOVAL

PLACE GARRISON DATE Sept 29 1939

19. UNDERTAKER Neighbors

20. FILED Oct 6 1939 W. L. Jones Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) SEPT 28th 1939

22. I HEREBY CERTIFY, That I attended deceased from SEPT 29th 189, to SEPT 28th 189

I last saw him alive on _____, 19____. Death is said

to have occurred on the date stated above, at 1:30 p.m.

The principal cause of death and related causes of importance were as follows:

Premature

Date of onset

Other contributory causes of importance:

Miscarriage

8-30-39

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 Dr. William H. Wilson M-D.

(Signed) 1772 (Address) SpARTA, MISSOURI

Every item of information should be as correctly supplied as possible. A copy of this certificate is sent to the State Board of Health. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

RECEIVED

District Health Officer No. 6,

District File Number 1039-2008

Date Filed OCT 9 1939