

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

36577
Do not use this space.

NOV 10 1939

1. PLACE OF DEATH
 (a) County Livingston Registration District No. 508
 (b) Township Lehlicoth Primary Registration District No. 3026
 (c) City Lehlicoth (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Sylvester Way
 (a) Residence, No. 200 Bridge St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Margaret Way
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 20, 1849
 7. AGE YEARS 90 MONTHS 3 DAYS 28 If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer Ret
 9. Industry or business in which work was done, as saw mill, bank, etc. Blacksmith
 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) Indiana
 FATHER 13. NAME Macy Way
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Weychester Va
 MOTHER 15. MAIDEN NAME Margaret Gray
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Richmond Va
 17. INFORMANT (ADDRESS) Cyrina Shour
Shawsville MO
 18. BURIAL, CREMATION, OR REMOVAL PLACE Jones beam DATE Oct 20, 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Ward Gordon
Lehlicoth MO
 20. FILED 10-19-39 W. Moore, M.D.
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct-18-1939
 22. I HEREBY CERTIFY, That I attended deceased from Oct 18, 1939 to Oct 18, 1939
 I last saw him alive on Oct 18, 1939. Death is said to have occurred on the date stated above, at 10:00 m.
 The principal cause of death and related causes of importance were as follows:
Cerebral hemorrhage
 Date of onset 10/18/39
 Other contributory causes of importance: 82 yr
 Name of operation none Date of _____
 What test confirmed diagnosis Cholesterol 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) W. C. Cooper, M. D.
 (Address) Chillicothe 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECORDED

District Health Officer No. 11

District File No. 1139-1371

Date Filed NOV 12 1959 *****

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.

working under my personal supervision.

Signed *James D Gordon*

Licensed Embalmer No. *1870*

P. O. Address *Lehillicothe Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.