21 1929

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

Do not use this space.

39335

1. PLACE OF DEATH
County Barry Registration District No. 20
Township Cassville Creek Primary Registration District No. 2005 File No.
City St. Ward) Registered No. 3

2. FULL NAME John Jaster,

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W.	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 7 - 1882

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ____ hrs. or ____ min.
	46	10	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer,
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Barry Co -

PARENTS
10. NAME OF FATHER Pete Jaster,
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Tallapoosa,
12. MAIDEN NAME OF MOTHER Mary Spunkie
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Barry,

14. INFORMANT Mrs John Jaster,
(Address) Bruce Field Mo

15. FILED 7/12, 1928 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 11 - 1928

17. I HEREBY CERTIFY, That I attended deceased from Aug 11th, 1928, to Aug 11 - 1928, that I last saw h. alive on Sept 14, 1928, and that death occurred, on the date stated above, at 12 30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? no. DATE OF —
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) C. E. Wright, M. D
, 19 (Address) Purcell City Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Bruce Field Mo.	Dec 13 1928
20. UNDERTAKER Wm Russell Dr.	ADDRESS Purcell City 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.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County Barry Registration District No. 30 File No.
Township Cappo Creek Primary Registration District No. 5 8 4 4 Registered No. 3
City (No. St. Ward)

2. FULL NAME John Foster

(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(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.

N. B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. [illegible] PHYSICIANS should state [illegible] of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	M

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.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 12-13 19 29 W R West
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 11 1928

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....
that I last saw h.... alive on ....., 19...., and that death occurred, on the date stated above, at ....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis of Lungs
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY)
(duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ....., M. D
....., 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY 31

S-39335