

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

APR 26 1935

1. PLACE OF DEATH

County St. Genevieve
Township Union
City Union (No.)

Registration District No. 934
Primary Registration District No. 6026

File No. 6679
Registered No. 2
St. Ward

2. FULL NAME

(a) Residence. No. St. Genevieve Co St.
(Usual place of abode)

Length of residence in city or town where death occurred all life yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 14-1878

7. AGE YEARS 56 MONTHS 3 DAYS — IF LESS than 1 day, — hrs. or — min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farm
(b) General nature of industry, business, or establishment in which employed (or employer) Farm
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) near Farmington
(State or Country) Mo

10. NAME OF FATHER Jesse O. Babbs

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo
(State or Country) Mo

12. MAIDEN NAME OF MOTHER Sarah Park

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Francis
(State or Country) Mo

14. INFORMANT Jesse O. Babbs
(Address) Farmington Mo

15. FILED 3/29/35 1935 Wm A Kott
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 13 1935

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1931 to Feb 13 1935 that I last saw h. live alive on Feb 13 1935, and that death occurred, on the date stated above, at 10:15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

(duration) 7 yrs. 23 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? no.

WHAT TEST, CONFIRMED DIAGNOSIS? Sputum - X-ray etc

(Signed) Geo. L. Walther, M. D.

Address Farmington Mo

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Little Vine DATE OF BURIAL 2/15/1935

20. UNDERTAKER Caldwell Bros ADDRESS Flat River 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.

THIS IS A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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.

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)
 Length of residence in city or town where death occurred yrs. mos. ds. (if nonresident give city or town and State)
 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 (enter 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. 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)

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..... 19.....

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED..... (duration)..... yrs. mos. ds.

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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS