

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

Do not use this space.

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1. PLACE OF DEATH

County Callaway
Township _____
City Fulton (No. _____)

Registration District No. 104
Primary Registration District No. 3008

File No. _____
Registered No. 120
St. _____ Ward _____

2. FULL NAME George Washington Herring

(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 Male 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 _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 4/14 1846

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
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8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER George Washington Herring

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

12. MAIDEN NAME OF MOTHER Lucy Simcoe

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

14. INFORMANT Judge D.W.Herring
(Address) Fulton Mo.

15. FILED _____, 19 _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/18 19 29

17. I HEREBY CERTIFY, That I attended deceased from _____
_____ 19 _____ to _____ 19 _____
that I last saw him alive on _____ 14 _____, 19 _____ and that
death occurred, on the date stated above, at _____
_____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma Left Shoulder
Arterial thrombosis
EMER

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 44

(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

19. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS Physical examination
(Signed) W. H. Herring, M. D.

, 19 _____ (Address) Fulton 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 Hillcrest Cemetery DATE OF BURIAL 6/16 19 29

20. UNDERTAKER Herndon Taylor ADDRESS Fulton Mo.

PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. AGE should be properly classified. Exact statement of OCCUPATION is very important. INFORMATION should be given in plain terms, so that it may be properly classified.

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**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Callaway Registration District No. 104 File No. _____
 Township _____ Primary Registration District No. 3008 Registered No. 120
 City Gulston (No. _____) St. _____ Ward _____

2. FULL NAME

George Washington Hewing
 (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 <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>wid</u>		
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)			

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-18-1929

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 19____ that I last saw him _____ alive on _____, 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 _____
 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.

14. INFORMANT _____ (Address)	19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____	DATE OF BURIAL _____ 19____
15. FILED <u>June 15</u> 19 <u>29</u> <u>R. W. Grews</u> REGISTRAR	20. UNDERTAKER _____	ADDRESS _____

SUPPLEMENTARY

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

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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