

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

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 **80739**

PLACE OF DEATH  
County Ray Co Mo  
Township Richmond Registration District No. 744 File No. \_\_\_\_\_  
or \_\_\_\_\_ Primary Registration District No. 3976B Registered No. 189  
Village L City \_\_\_\_\_ (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
City \_\_\_\_\_ (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
FULL NAME Henry Giles

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
SEX <u>Male</u>	COLOR OR RACE <u>Black</u>	SINGLE MARRIED <u>Widowed</u> WIDOWED OR DIVORCED (Write the word)	DATE OF DEATH <u>Dec 19</u> (Month) _____ (Day) _____ (Year) <u>1913</u>	
DATE OF BIRTH <u>June 15</u> , 18 <u>48</u> (Month) _____ (Day) _____ (Year)		I HEREBY CERTIFY, that I attended deceased from <u>Dec 20</u> , 191 <u>3</u> , to _____, 191 <u>3</u> , that I last saw h <u>✓</u> alive on _____, 191 <u>3</u> , and that death occurred, on the date stated above, at _____ m.		
AGE <u>65</u> yrs. <u>3</u> mos. <u>4</u> ds.		The CAUSE OF DEATH* was as follows: <u>found dead at edge of crossing near Hardin mo Wesley Head of bridge No. 2000 of State</u> (Duration) _____ yrs. _____ mos. _____ ds.		
OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Family</u>		Contributory <u>Don't know</u> (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.		
BIRTHPLACE (City or town, State or foreign country) <u>Ray Co Mo</u>		(Signed) <u>Harold Harris</u> <u>Dec 20</u> , 191 <u>3</u> (Address) <u>Richmond Mo</u>		
PARENTS	NAME OF FATHER <u>Don't know</u>	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
	BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Don't know</u>	LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
	MAIDEN NAME OF MOTHER <u>Don't know</u>	Where was disease contracted If not at place of death? Former or usual residence _____		
	BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Don't know</u>	PLACE OF BURIAL OR REMOVAL <u>Giles Cemetery</u> DATE OF BURIAL <u>Dec 22</u> , 191 <u>3</u>		
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>James Hill</u> (ADDRESS) <u>Hardin mo</u>		UNDERTAKER <u>Shirley D &amp; Co Richmond Mo</u>		
Filed <u>Dec 22</u> , 191 <u>3</u> <u>Geo W Hunt</u> <u>Reg</u> REGISTRAR		ADDRESS <u>Richmond Mo</u>		

**MISSOURI STATE BOARD OF  
BUREAU OF VITAL STATIS  
CERTIFICATE OF DEATH**

**Revised United States Standard Certificate  
of Death**

[Approved by U. S. Census and American Public Health Association]

**PLACE OF DEATH** \_\_\_\_\_

County \_\_\_\_\_

Township \_\_\_\_\_ or \_\_\_\_\_ File No. \_\_\_\_\_

Village \_\_\_\_\_ or \_\_\_\_\_ Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_

City \_\_\_\_\_ (NO. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**FULL NAME** \_\_\_\_\_

**PERSONAL AND STATISTICAL PARTICULARS**

<b>SEX</b>	<b>COLOR OR RACE</b>	<b>MARITAL STATUS</b> SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
<b>DATE OF BIRTH</b> _____, _____, 191____, at _____	<b>AGE</b> _____, _____, mos., _____ ds.	<b>IF LESS than</b> 1 day, _____ hrs., _____ min.?
<b>OCCUPATION</b> (a) Trade, Profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____		

**BIRTHPLACE**  
(City or town, State or foreign country) \_\_\_\_\_

**NAME OF FATHER** \_\_\_\_\_

**BIRTHPLACE OF FATHER**  
(City or town, State or foreign country) \_\_\_\_\_

**MAIDEN NAME OF MOTHER** \_\_\_\_\_

**BIRTHPLACE OF MOTHER**  
(City or town, State or foreign country) \_\_\_\_\_

**PARENTS**

**THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**  
(Informant) \_\_\_\_\_

(ADDRESS) \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

**DATE OF DEATH** \_\_\_\_\_ (Month) \_\_\_\_\_

**I HEREBY CERTIFY, that I attended**  
that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_  
and that death occurred, on the date stated ab \_\_\_\_\_  
**The CAUSE OF DEATH\* was as follows:** \_\_\_\_\_

**Contributory**  
(SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs.

(Signed) \_\_\_\_\_ (Duration) \_\_\_\_\_ (Address) \_\_\_\_\_

\*State the Disease Causing Death, or, in deaths from (1) Means of Injury; and (2) whether Accidental, Suicidal, or Floor LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTION, RECENT RESIDENTS)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_  
Where was disease contracted if not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

**PLACE OF BURIAL OR REMOVAL** \_\_\_\_\_ **DATE OF** \_\_\_\_\_

**UNDERTAKER** \_\_\_\_\_ **ADDRESS** \_\_\_\_\_

Filed \_\_\_\_\_, 191\_\_\_\_, \_\_\_\_\_ **REGISTRAR**