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

Do not use this space.

23894

File No. ____

Registered No. 38

1. PLACE OF DEATH

94 County St Francois Registration District No. 775

Township Penny Primary Registration District No. 6 0 x 0

City Bonne Terre Mo (No. ____ St. ____ Ward)

2. FULL NAME Donald Eugene Mabery

(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.

AUG 8 7 1932

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feby 16-1932

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	4	21	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Bonne Terre Mo

(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Ralph Mabery

11. BIRTHPLACE OF FATHER (CITY OR TOWN) ____

(STATE OR COUNTRY) Pilot River Mo

12. MAIDEN NAME OF MOTHER Velma Goins

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ____

(STATE OR COUNTRY) Bonne Terre Mo

14. INFORMANT Ralph Mabery

(Address) Bonne Terre Mo

15. FILED 7/[illegible] 1932 T. A. Son REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 7 1932

17. I HEREBY CERTIFY, That I attended deceased from July 3 1932, to July 7 1932, that I last saw h— alive on ____ 19____, and that death occurred, on the date stated above, at 7 P. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Acute Catarrhal Dysentery

1 day

1 day (duration) ____ yrs. ____ mos. 2 ds.

CONTRIBUTORY (SECONDARY) ____

(duration) ____ yrs. ____ mos. ____ ds.

18. WHERE WAS DISEASE CONTRACTED ____

IF NOT AT PLACE OF DEATH? At Home

DID AN OPERATION PRECEDE DEATH? No DATE OF ____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Examination

(Signed) Lee Tinsley, M. D

7-9, 1932 (Address) Bonne Terre 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: B T Cemetery — DATE OF BURIAL: 7/8 1932

20. UNDERTAKER: Benham Und Co. — ADDRESS: Bonne Terre Mo

1932-7-7 / 15

1932-2/4-21