

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

1 PLACE OF DEATH

County

Township

or

Village

or

City *Spain* (NO. *1900*)

Registration District No. *781*

File No. *3462*

Primary Registration District No. *1008*

Registered No. *72*

City *City Hospital* (NO. *19* Ward)

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

2 FULL NAME *Nathaniel Perry*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *Colored* 5 SINGLE *Single*
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6 DATE OF BIRTH *Dec 5 1915*
(Month) (Day) (Year)

7 AGE *28* yrs. mos. ds. IF LESS than 1 day, hrs. or min.?

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

9 BIRTHPLACE (City or town, State or foreign country) *Spain*

10 NAME OF FATHER *Wesley Barry*

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *Tennessee*

12 MAIDEN NAME OF MOTHER *Nasua Payne*

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Illinois*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) *Ernest*

(Address) *City Hospital*

15 Filed *Nov 3 1916* *Paul Starkloff* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Jan 2 1916*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *Dec 15 1915* to *Jan 2 1916* that I last saw *him* alive on *Jan 2 1916* and that death occurred, on the date stated above, at *5:45*

The CAUSE OF DEATH* was as follows:
1610

Septicaemia following Infected Umbilicus
(Duration) yrs. mos. ds.

CONTRIBUTORY *Mal nutrition*
(Secondary) (Duration) yrs. mos. ds.

(Signed) *P. W. Keippel* M. D. *Jan 2 1916* (Address) *City Hospital*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death yrs. mos. ds. *18* In the State yrs. mos. ds. *28*

Where was disease contracted if not at place of death? Former or usual residence *1613 Glasgow*

19 PLACE OF BURIAL OR REMOVAL *Greenwood Cemetery* DATE OF BURIAL *Jan 3 1916*

20 UNDERTAKER *J. W. Hughes* ADDRESS *2620 S. Avator*

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.

