

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

40102

**1. PLACE OF DEATH**

County Jackson Registration District No. \_\_\_\_\_ File No. \_\_\_\_\_  
 Township Union Primary Registration District No. \_\_\_\_\_ Registered No. \_\_\_\_\_  
 City Union City (No. General Hospital) \_\_\_\_\_ St. 11 (Ward)

**2. FULL NAME**

(a) Residence No. Homey, actual Ward \_\_\_\_\_  
 (Usual place of abode) \_\_\_\_\_ (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred yrs. 1 mos. 5 ds. How long in U.S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 28 1918

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

17. I HEREBY CERTIFY, That I attended deceased from Nov 27 1918 to Nov 28 1918 that I last saw deceased alive on Nov 28 1918, and that death occurred, on the date stated above, at 9:55 P.M.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 22 1901

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAY H LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
17 3 6

Bronchopneumonia  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**8. OCCUPATION OF DECEASED**

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

CONTRIBUTORY (SECONDARY) Asphyxia  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

9. BIRTHPLACE (CITY OR TOWN) Uniontown  
 (STATE OR COUNTRY) \_\_\_\_\_

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH: Unknown

10. NAME OF FATHER Unknown

DID AN OPERATION PRECEDE DEATH: No DATE OF \_\_\_\_\_

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

WHAT TEST CONFIRMED DIAGNOSIS: Aspiral

12. MAIDEN NAME OF MOTHER Unknown

(Signed) Chas. E. Ross, M. D.  
 11/28, 1918 (Address) San Diego, Cal.

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

\*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.)

14. INFORMANT (Address) H. G. Brown  
1124 N. 6th

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL  
1124 N. 6th Nov 1 1918

15. FILED 11/1 1918 REGISTRAR

20. UNDERTAKER ADDRESS  
Carroll & Mack 1915 East 13th

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.

