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

PLACE OF DEATH

County Buchanan

Township Agency

or

Village "

or

City _____ (NO. _____ St.; _____ Ward)

Registration District No. 80 File No. 13064

Primary Registration District No. 4048 Registered No. 13

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

FULL NAME Joseph A. Nash

PERSONAL AND STATISTICAL PARTICULARS

SEX: male

COLOR OR RACE: white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): married

DATE OF BIRTH: Oct. (Month) 26 (Day), 1893 (Year)

AGE: 24 yrs. 5 mos. 19 ds.

If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work: Bookkeeper

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

BIRTHPLACE (City or town, State or foreign country): Missouria

PARENTS

NAME OF FATHER: Otto Nash

BIRTHPLACE OF FATHER (City or town, State or foreign country): N.Y.

MAIDEN NAME OF MOTHER: Lydia Stait

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ill.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nash (Brother)

(ADDRESS) Kan City Kan

Filed 4/15/19, 191__. R. L. Dowell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: April (Month) - 14 (Day), 1919 (Year)

I HEREBY CERTIFY, that I attended deceased from April 5, 1919, to April, 1919, that I last saw him alive on April 12, 1919, and that death occurred, on the date stated above, at 7 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

23 H

28

(Duration) 1 yrs. 0 mos. 0 ds.

Contributory (SECONDARY) none

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Dr. S. E. Meluney M. D.

April 15 1919 (Address) Agency Mo

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

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL: Agentine Kan

DATE OF BURIAL: 4/16/19, 191__

UNDERTAKER: Bruns & Waddell

ADDRESS: Agency Mo

MAR 18 1948

FEB 26 1948

PLACE OF DEATH

County _____

Township _____ or

Village _____ or

City _____ (NO. _____, _____ St.; _____ Ward)

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

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

FULL NAME _____

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

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(*Write* the word)

DATE OF BIRTH

_____ (Month) _____ (Day), 1_____ (Year)

AGE

_____ yrs. _____ mos. _____ ds.

If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(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)

PARENTS

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)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____ (Month) _____ (Day), 191____ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

_____, 191____

UNDERTAKER

ADDRESS