

APR 22 1927

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

Do not use this space.

7314

1. PLACE OF DEATH

County Buchanan  
Township  
City St. Joseph,

Registration District No. 85  
Primary Registration District No. 1001  
(No. Missouri Hospital)

File No.  
Registered No. 280  
St. \_\_\_\_\_ Ward)

2. FULL NAME Ernest E Townsend

(a) Residence. No. Industrial City, St., \_\_\_\_\_ Ward.  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May. 14, 1874.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
52 9 27

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Unknown  
(STATE OR COUNTRY) Minnesota

10. NAME OF FATHER David Townsend

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Ernest E Townsend  
(Address) Industrial City, MO.

15. FILED MAR 16 1927 John G. Webb REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March. 11. 1927

17. Inquested

I HEREBY CERTIFY, That I attended deceased from March. 11, 1927, to \_\_\_\_\_, 19\_\_\_\_, that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 1/45 p., 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Fracture of skull struck by E. & W. Railroad gasoline motor train (Accidental) (duration) \_\_\_\_\_ yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 206 M. (duration) \_\_\_\_\_ yrs. mos. ds.

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

8 DID AN OPERATION PRECEDE DEATH: \_\_\_\_\_ DATE OF \_\_\_\_\_

9 WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Post mortem findings  
March. 14, 1927 (Signed) Dr. Wm. H. Coroner, M. D.  
St. Joseph Mo (Address)

\*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 DATE OF BURIAL

St. Joseph Memorial Park Cem March. 17 1927

20. UNDERTAKER H. O. Sidenfaden ADDRESS 1802 Union St

JUL 23 1951

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

ALL INFORMATION CONTAINED  
HEREIN MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH  
 County Buchanan Registration District No. 85- File No. ....  
 Township St. Joseph Primary Registration District No. 1001 Registered No. 280  
 City St. Joseph (No. ....) St. .... Ward) .....

2. FULL NAME Ernest E. Townsend  
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

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

|        |       |        |      |                                  |
|--------|-------|--------|------|----------------------------------|
| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, hrs. or min. |
|        |       |        |      |                                  |

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work .....

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

(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) .....

10. NAME OF FATHER .....

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

12. MAIDEN NAME OF MOTHER .....

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

14. INFORMANT (Address) .....

15. 3/16 1927 John G. [Signature] REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 11 - 19 27

17. I HEREBY CERTIFY That I attended deceased from .....  
 that I last saw him ..... alive on ..... 19....., and that death occurred, on the date stated above, at .....

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Fractured skull - struck by C. & S. P. railroad gasoline motor-car (accident)  
 (duration) ..... yrs. .... mos. .... da.

CONTRIBUTORY (SECONDARY) was in automobile  
 (duration) ..... yrs. .... mos. .... da.

18. WHERE WAS DISEASE CONTRACTED 1880  
 IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? .....

DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) [Signature], M. D.  
 , 1927 (Address) .....

\*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.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL .....

DATE OF BURIAL .....

20. UNDERTAKER .....

ADDRESS .....

**SUPPLEMENTARY**

THIS IS A PERMANENT RECORD  
 ARE COMPLETE AS PRESCRIBED BY LAW  
 N. B.—Every item of information should be carefully supplied. A fee should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH as fully as possible so that it may be properly classified. Exact statement of occupation should be given. FAMILIAR PARTIES SHALL NOT RECEIVE A FEE FOR THIS SERVICE.

9-13-12