

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

Do not use this space.

11057

1. PLACE OF DEATH

County Buchanan
Township _____
City St. Joseph Mo.

Registration District No. 85
Primary Registration District No. 201
(No. Noyes Hosp.)

File No. _____
Registered No. 444
St. _____ Ward _____

2. FULL NAME Joseph Mecum

(a) Residence No. 11057 Buchanan St. _____ Ward _____
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Not Known

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Not Known

6. DATE OF BIRTH (MONTH, DAY AND YEAR) not known 1849

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
78 * * *

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mason
(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) Buchanan Mo.

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER Mrs. [unclear]

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

14. INFORMANT Mrs Lawrence Sheldon, (sister)

15. ADDRESS Lincoln Ave. 45 [unclear]

FILED APR 28 1927 19 John G. [unclear] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April, 23, 27. 19 27

17. I HEREBY CERTIFY, That I attended deceased from Mar 12, 1927, to Apr 23, 1927, that I last saw h. him alive on Apr 23, 1927, and that death occurred, on the date stated above, at 3:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho Pneumonia
107A
100W
(duration) yrs. mos. 11 da.

CONTRIBUTORY Smoking (SECONDARY)
(duration) yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Signs & Symptoms
(Signed) Clarence A. [unclear] M. D.

Apr 27, 1927 (Address) St Joseph 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 DATE OF BURIAL

City Cemetery Apr. 28 1927

20. UNDERTAKER ADDRESS
Rock Funeral Home 9ty / Sylvan

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.

THIS IS A PERMANENT RECORD

MAY 25 1927

