

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.

200984

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

Do not use this space.

11929

1. PLACE OF DEATH

County Jackson
Township Kaw
City St. Joseph (No. St. Joseph Hosp)

Registration District No. 388
Primary Registration District No. 100

File No. 1725
Registered No. 1725
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 1 mos. _____ ds. _____

Salina Kas
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 24th 1861

7. AGE YEARS 65 MONTHS 8 DAYS 19 If LESS than 1 day, _____ hrs. _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work President 130 93A
(b) General nature of industry, business, or establishment in which employed (or employee) Farmers Union
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Nebr

10. NAME OF FATHER

Edna Tromble

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Nebr

12. MAIDEN NAME OF MOTHER

Frieda Cook

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Ill

14.

INFORMANT Mrs Nettie Tromble
(Address) Salina Kas

15.

FILED 4/26-27 1927 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/25/27 1927

17. I HEREBY CERTIFY, That I attended deceased from morning 2:40, 1927, to even 2:5, 1927 that I last saw him alive on April 25th 1927, and that death occurred, on the date stated above, at 4:05 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Ac Myocarditis with Dilatation
exacerbation of a chronic case
(duration) _____ yrs. 1 mos. 3 ds.
CONTRIBUTORY (SECONDARY) Nephritis Ac - exacer-
bation of Chronic Case
(duration) _____ yrs. 1 mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF BIRTH? No

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Laboratory, Clin. Micro

(Signed) Calvin L. Cooper, M. D.
4/26, 1927 (Address) 626 W. 1st St. Salina Kas

*State the DISEASE CAUSING DEATH, or if Shif (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Salina Kas

DATE OF BURIAL

4/26/27 1927

20. UNDERTAKER

W. J. Mayberry Co

ADDRESS

City

Dr Calvin Cooper