

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

Do not use this space.

19139

1. PLACE OF DEATH

County..... Registration District No. 791
Township..... Primary Registration District No. 1003
City Spain (No. Cely Hospital)

File No. 13440
Registered No. 13440
St. Ward

2. FULL NAME

William Underwood

(a) Residence. No. 1608 P3 St. 13 Ward.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 40 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 Emma

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 27 1873

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>54</u>		<u>10</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) himself
(c) Name of employer

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

10. NAME OF FATHER ? Underwood

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

12. MAIDEN NAME OF MOTHER ? Unknown

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

14. INFORMANT Hospital Informant
(Address) City Hospital

15. FILED APR -9 1927 Max G. Starceoff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 7 1927

17. I HEREBY CERTIFY That I attended deceased from April 2 1927 to April 7 1927 that I last saw him alive on April 7 1927 and that death occurred, on the date stated above, at 8:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
936

CONTRIBUTORY (SECONDARY) 90 B

18. WHERE WAS DISEASE CONTRAICTED
IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Thos. J. Miller M.D.
4/8 1927 (Address) Cely Hospital

*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 no hope DATE OF BURIAL Apr. 11 1927

20. UNDERTAKER C. Hoffmeister U. & S. Co. ADDRESS 78 1/2 S. Perry

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.

Mudenoord