AUG 1

1927

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

Do not use this space.

20678

File No. 676

Registered No.

1. PLACE OF DEATH

County: Buchanan

Township:

City: St Joseph (No. ..... St. ..... Ward)

Registration District No. 85

Primary Registration District No. 1001

2. FULL NAME: Thomas Means

(a) Residence. No. State Hospital #2 St., ... Ward. Corning Mo
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 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): Single.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): About 1859

7. AGE: Years 68 Months Unknown Days ..... If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farm Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

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

PARENTS

10. NAME OF FATHER: Irving Means.

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

12. MAIDEN NAME OF MOTHER: Unknown

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

14. INFORMANT: Albert Means (Address) Corning Mo.

15. FILED ..... 19..... John G. Jeffries, Registrar

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Aug. 7. 1926 to July 7 1927 that I last saw him alive on July 7. 1927, and that death occurred, on the date stated above, at 4.30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arteriosclerosis 9 1

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 9 1 8

(duration) ..... yrs. ..... mos. ..... ds.

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

(1) DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical.

(Signed) J. R. Burch, M. D

7/7/ 1927 (Address) State Hospital #2

*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: Corning Mo

DATE OF BURIAL: 7/9 1927

20. UNDERTAKER: J. L. Abernathy

ADDRESS: 2160 10th

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.