

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

Do not use this space.

1. PLACE OF DEATH

County Buchanan Registration District No. 85
 Township St. Joseph Primary Registration District No. 1001
 City St. Joseph (No. St. Joseph Hospital 2) St. Ward

File No. 29573
 Registered No. 1027

2. FULL NAME

(a) Residence. No. Bonnieville St. Bonnieville No. Ward. Bonnieville No.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 1 yrs. 5 mos. 53 da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Male White Single

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

Bonnieville

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

Apr 18 46

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

81 Unknown

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

None

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

14.

INFORMANT (Address)

St. Joseph Hosp Rec
St. Joseph, Mo.

15.

FILED OCT 7 1927

John G. Webb
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 6 19 27

17. I HEREBY CERTIFY, That I attended deceased from Oct 4 1927 **to** Oct 6 1927
 that I last saw h. she alive on Oct 6 1927, and that death occurred, on the date stated above, at 430 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cardio-renal disease
95B Arterio-sclerosis
97 (duration) yrs. mos. da.
162

CONTRIBUTORY (SECONDARY) Senile Dementia
 (duration) yrs. mos. da.

18. WHEN SWAL DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? Unknown

19. DID AN OPERATION PRECEDE DEATH? No DATE OF —

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Dr. Leonard Garton, M.D.
106, 1927 (Address) St. Joseph Mo.

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Keokville Mo **DATE OF BURIAL** 10 19 27

20. UNDERTAKER J L Buckley **ADDRESS** 216 20 1028

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.

83-1927-182

