

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

Do not use this space.

39964

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City.....

File No. **1**

Registered No. **21**

St.

Ward)

2. FULL NAME

(a) Residence. No. **1406 N 12th** St., **N 5** Ward.

(Usual place of abode)

(If nonresident give city or town and State)

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.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Married**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Dec 30 1928**

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

17. I HEREBY CERTIFY, That I attended deceased from **Dec 13**, 19**27**, to **Dec 30**, 19**28**, that I last saw him alive on **Dec 30**, 19**27**, and that death occurred, on the date stated above, at **1:30 AM**.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **May 8 - 1886**

THE CAUSE OF DEATH* WAS AS FOLLOWS: **Lobar pneumonia of left chest & Empyema.**
(Stage 1. Pleuritic stage culture)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
41 7 22

CONTRIBUTORY **Acute pericarditis**
(SECONDARY) **(to empyema)** (duration) yrs. mos. da.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH **101 W**

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Palau**

DID AN OPERATION PRECEDE DEATH? DATE OF

10. NAME OF FATHER **W. J. ...**

WAS THERE AN AUTOPSY? **yes**

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

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **John ...**, M. D.
12/30/28 (Address) **Chey Hospital**

12. MAIDEN NAME OF MOTHER **Lynn**

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

*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.

14. INFORMANT (Address) **Chey Hospital**

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Calvary Cem **7-2-1928**

15. JAN -2 1928 FILED **Mar 8 1928** REGISTRAR

20. UNDERTAKER ADDRESS
Central Ind Co **1841 Cass**

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.

Kozłowski

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