

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

Do not use this space.

7850

1. PLACE OF DEATH

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

File No. _____
 Registered No. 188
 St. _____ Ward _____

2. FULL NAME

J. E. T. Speerell
 (a) Residence. No. Kansas City, Mo. St. _____ 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. 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 about

6. DATE OF BIRTH (MONTH, DAY AND YEAR) unknown 1886

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
42 unknown

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labour
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) unknown

10. NAME OF FATHER unknown

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT State Hospital Record
St. Joseph

15. FILED 1928 REGISTERAR J. M. J. W. E. A. Sidenfaden

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/4/28 19

17. 2/22/27 HEREBY CERTIFY, That I attended deceased from _____, 19, to 3/4/28, 19, that I last saw him _____ alive on 3/3/28, 19, and that death occurred, on the date stated above, at _____, Mo.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General Paresis
83 (duration) yrs. mos. ds.
 CONTRIBUTORY Paralytic Convulsion
 (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical

(Signed) J. M. J. W. E. A. Sidenfaden, M. D.

3/7, 1928 (Address) State 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 DATE OF BURIAL

Ashland Cemetery March 7 1928

20. UNDERTAKER ADDRESS E. A. Sidenfaden 602 So. 10

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.

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