JUL 6 1928

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

Do not use this space.

File No. 13666

Registered No. 68

1. PLACE OF DEATH

County: Jackson — Registration District No. 400

Township: Prairie — Primary Registration District No. 5553 B

City ..... (No. ....., ... St. ..... Ward)

2. FULL NAME: John Humphreys

(a) Residence. No. ..... Jackson Co. Home Street ..... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 3 mos. 14 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1-20-1859

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	69	3	10	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN): Albia
(STATE OR COUNTRY): Iowa

PARENTS

10. NAME OF FATHER: Wm Humphreys

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

12. MAIDEN NAME OF MOTHER: Nancy Turner

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

14. INFORMANT: W. Hostetter
(Address): Dist. Jackson Co. Home

15. Filed May 3, 1928. F. M. Schick, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-30-1928

17. I HEREBY CERTIFY, That I attended deceased from March 16th, 1928, to April 30, 1928, that I last saw alive on April 26, 1928, and that death occurred, on the date stated above, at 9.45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Infection from abscess on forehead

181.A

195B (duration) yrs. mos. 7 ds.

CONTRIBUTORY (SECONDARY) 878 General infection

(duration) yrs. mos. 7 ds.

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

Did an operation precede death? Operation Date of 4/26-28

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. N. Greene, M. D.

, 19 (Address) Independence Mo

*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
K. C. Western Dental Coll.	May 5 1928

20. UNDERTAKER	ADDRESS
Mo State Anatomical Board	Kansas City

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNLESS COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH

County: Jackson — Registration District No.: 400 — File No.:

Township: Prairie — Primary Registration District No.: 3-3-3-3 13 — Registered No.: 68

City: (No. , St. Ward)

2. FULL NAME John Humphreys

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

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M	W	S

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

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

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

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

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

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT
(Address)

15. Aug 9 28 F. M. Schick
Filed 19 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19, that I last saw h. alive on 19, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Infection from abscess on forehead due to acne.

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) General infection

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) , M. D.
, 19 (Address)

*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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY