

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.

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

Do not use this space.

22168

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **St. Louis** (No. **1003**) Station

File No.....
Registered No. **6346**
St. Ward)

2. FULL NAME

(a) Residence No. St. **65** Ward. **Corington Ky.**
(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

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)

7. AGE YEARS MONTHS DAY If LESS than 1 day, hrs. or min.
23 9 27

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)

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.

FILED
1928

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 15 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..... 5 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Hemorrhage
Pulmonary Tuberculosis
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. da.

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) **J. W. Kelone**, M.D.19. (Address) **604 S. 1st St. Cornington Ky.**

*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

Corington Ky
June 18 1928

20. UNDERTAKER

ADDRESS

M. H. Marshall
Union

