

CT 26 1928

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

Do not use this space.

430890

1. PLACE OF DEATH

County Jefferson

Registration District No. 475

Township Neylande

Primary Registration District No. 55-80

City..... (No.....)

File No. 43

Registered No. 43

2. FULL NAME Nicholas Meade

(a) Residence. No. Part 1, Catarissa, Mo. St. Mo.
(Usual place of abode)

Ward..... (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 1st 1892

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>35</u>	<u>10</u>	<u>0</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farm hand

(b) General nature of industry, business, or establishment in which employed (or employer) 114

(c) Name of employer Wm Oberkramer

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

10. NAME OF FATHER Nicholas Meade

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

12. MAIDEN NAME OF MOTHER Belle Lines

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

14. INFORMANT Mrs John Smith
(Address) Catarissa, Mo.

15. FILED 9/13/28 James A. Sours REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 1st 1928

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1928, to Aug 28, 1928, that I last saw him alive on Aug 28, 1928, and that death occurred, on the date stated above, at 4:15 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Abscess

CONTRIBUTORY (SECONDARY) Influenza
(duration)..... yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) James S. Sargent, M. D.

(Address) Eureka, Mo.

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Patrick's Rock Church DATE OF BURIAL Sept 3rd 1928

20. UNDERTAKER B. V. Scheer ADDRESS Catarissa, Mo.

Every item of information should be carefully supplied. AGE should be stated in FULL YEARS. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

may be found in the following cases: BB should be stated BB
and BB should be stated BB

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
 County Jefferson Registration District No. 425 File No. 8
 Township Waverly Primary Registration District No. 55-80 Registered No. 43
 City (No.) St. Ward)

2. FULL NAME Nicholas Meade
 (a) Residence. No. 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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

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 8 1928 James A. Townsend REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 1 - 1928

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary abscess, about 1 1/2 inches in diameter, with a fracture of the ribs.
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) traumatic
No fracture of ribs.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) [Signature] M. D.
 , 19 (Address) 185

*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

20. UNDERTAKER

DATE OF BURIAL

ADDRESS

N. 1. -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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-30896