

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

Do not use this space.

33617

399

1. PLACE OF DEATH

County Jackson

Registration District No. 1002

Township Man

Primary Registration District No. 1002

City Manassas City, Mo.

(No. St. Anthony Home)

File No. _____

Registered No. 1157

St. _____ Ward)

2. FULL NAME

(a) Residence, No. 2300 College St., 12 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)

Single

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

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

Supposed to be Oct 5 1928

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(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)

Kennett City Mo

10. NAME OF FATHER

not known

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 Sister at St Anthony Home

(Address) 2300 College

15.

FILED 10/12 1928 M. M. Crowe

REGISTRAR Mr. Crowe

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 10 1928

17. I HEREBY CERTIFY, That I attended deceased from Oct 6 1928, to Oct 10 1928, and that that I last saw him alive on Oct 10 1928, and that death occurred, on the date stated above, at 8 P m. 10711

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Atelectasis
1000 (duration) yrs. mos. ds. congenital
CONTRIBUTORY (SECONDARY) Pneumonia
(duration) yrs. mos. ds. 2

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS H. K. Sawyer

(Signed) H. K. Sawyer M.D.

10/10 1928 (Address) 214 Med. arts Bldg

*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

St. Mary's cemetery Oct 12 1928

20. UNDERTAKER

ADDRESS

John W. Wagner 1409 Grand Ave

WHITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

