

AN 21 1929

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

Do not use this space.

1. PLACE OF DEATH

County *Buchanan*
Township *Washington*
City *County Infirmary*

Registration District No. *86*
Primary Registration District No. *527*
(No. County Infirmary)

File No. *39590*
Registered No. *86*
St. _____ Ward _____

2. FULL NAME

William Cumming

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *unk*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *unk about 1850*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min. *78 unk*

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *unknown*
(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) *Ireland*

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 *County Infirmary* (Address) *Reynolds*

15. *Dec 8 28* REGISTRAR *J. J. Bausch*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 7 1928*
17.

I HEREBY CERTIFY That I attended deceased *1800 1st* 15th to *Dec 7 to* 19th 1928 that I last saw h. *unk* alive on *Dec 7th* 5:30 P.M. and that death occurred, on the date stated above, at _____ P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

97
162 Arterio Sclerosis
(duration) *5* yrs. mos. da.
CONTRIBUTORY *Senile Dementia*
(SECONDARY) (duration) *1* yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? *NO*

DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*
(Signed) *Albert E. Holley* M. D.
Dec 8th 28 (Address) *822 Edmond St. High Mo*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE CAUSES, state (1) MEANS and NATURE of INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *City Cem* DATE OF BURIAL *12/8 1928*

20. UNDERTAKER *Fleeman Funeral Home* ADDRESS *1708 Francis*

WRITE 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.

