

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

Do not use this space.

40129

1. PLACE OF DEATH

County Jackson
Township Central
City (No. _____) _____

Registration District No. 284
Primary Registration District No. 4-409-B

File No. _____
Registered No. 80
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward. N. Main Mo
(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? 1 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male | **4. COLOR OR RACE** White | **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Single
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1927

7. AGE
YEARS: 1 MONTHS: 6 DAYS: ✓
IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant
(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) Washington Co Mo

10. NAME OF FATHER John Head

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

12. MAIDEN NAME OF MOTHER Alberta Mey

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

14. INFORMANT (Address) John Head - N. Main Mo

15. FILED 12/29/28 W.E. Kelleher REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec - 28 1928
17.

I HEREBY CERTIFY, That I attended deceased from Dec 28, 1928, to Jan 28, 1929, that I last saw alive on Dec 28, 1928, and that death occurred, on the date stated above, at 1 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Branchial Pneumonia
IIA
107A (duration) yrs. mos. da.

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH. Mo

0 DID AN OPERATION PRECEDE DEATH? DATE OF ✓
WAS THERE AN AUTOPSY? Mo

WHAT TEST CONFIRMED DIAGNOSIS? Culture
(Signed) W. H. ... M. D.
12/29, 1928 (Address) N. Main 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 God Frelans Cemetery **DATE OF BURIAL** 12/29 1928

UNDERTAKER M.B. ... **ADDRESS** N. Main Mo



**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 Franklin Registration District No. 294 File No.
 Township Central Primary Registration District No. 3409 B Registered No. 20
 City Thomas McKinley (No.) St. Ward)

2. FULL NAME

Thomas McKinley E. Head
 (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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9/18/1927

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (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) 2/9/27 W.E. Stetzel

15. FILED 2/9/27 W.E. Stetzel REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 28 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:

CONTRIBUTORY (SECONDARY) (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

20. UNDERTAKER ADDRESS

COPIES SHALL NOT BE RECEIVED UNTIL THEY ARE COMPLETE AS PRESCRIBED

SUPPLEMENTARY

S-40129