

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

Do not use this space.

42983

1. PLACE OF DEATH

County.....
Township.....
City.....

791
1002

Registration District No.....
Primary Registration District No.....
(No. 619 No. Leonard)

File No.....
Registered No. 12257
St..... Ward.....

2. FULL NAME

(a) Residence No. 619 No. Leonard St., 21 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 <i>Male</i>	4. COLOR OR RACE <i>Colored</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF <i>Florence Mauderwille</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Unknown</i>		
7. AGE YEARS <i>abt 38</i>	MONTHS <i>-</i>	DAYS <i>-</i>
IF LESS than 1 day, hrs. or min.		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
Laborer

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Atlanta Ga*
(STATE OR COUNTRY)

10. NAME OF FATHER *Joshua Mauderwille*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Ga*
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT *Florence Mauderwille*
(Address) *619 No Leonard St*

15. FILED *DEC 17 1928*
Max C. Stubbins
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Dec 14 1928*

17. I HEREBY CERTIFY, That I attended deceased from *June 14 1928* to *Dec 14 1928*
that I last saw him alive on *Dec 12 1928* and that death occurred on the date stated above, at *12 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis Pulmonary
34
23 ft
Several years (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) *Two*
Several years (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, *To*
19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF
WAS THERE AN AUTOPSY? *No*
WHAT TEST CONFIRMED DIAGNOSIS? *Phys Ray Sputum & Blood*
(Signed) *J. P. Paugh*, M. D.
12/14 1928 (Address) *5812 Delmar*

*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 *Greenwood* **DATE OF BURIAL** *12/18 1928*

20. UNDERTAKER *W. Roberts wife* **ADDRESS** *3035 Lucas St*

WRITE PAINLY, 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.

