

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

Do not use this space. 285

1. PLACE OF DEATH

County Buchanan Registration District No. 85 File No. _____
 Township _____ Primary Registration District No. 1081 Registered No. 42 Hospital
 City St. Joseph (No. ~~to St. Joseph~~)

2. FULL NAME

William Garbrie
 (a) Residence, No. Unknown St. _____ Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 2 yrs. _____ mos. _____ da. How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Mal **4. COLOR OR RACE** wh **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Unmarried

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown 1872

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>57</u>	<u>X</u>	<u>X</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Market Gardener
 (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) New York

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 As Accora
 (Address) As

15. FILED JAN 7 1928 **REGISTRAR** Ed. O.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 7th 1928

17. I HEREBY CERTIFY, That I attended deceased from Dec 4, 1927, to Jan 6th, 1928, that I last saw him alive on Jan 6th, 1928, and that death occurred, on the date stated above, at St. Joseph m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Erysipelas 15 B
2/10 (duration) _____ yrs. _____ mos. 11 da.

CONTRIBUTORY (SECONDARY) Unknown
 (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED County Infirmary
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? None
 (Signed) Lois P. Bode M. D.
1/9, 1928 (Address) St Joseph, 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 City Cem **DATE OF BURIAL** 1/9 1928

20. UNDERTAKER J. L. Blum **ADDRESS** 216 00 102

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

N. E.—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.

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