

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

Do not use this space.

368

1. PLACE OF DEATH

County Buchanan Registration District No. 85 File No. _____
 Township _____ Primary Registering District No. 1001 Registered No. 129
 City St Joseph (No. State Hospital # 2) St. _____ Ward _____

2. FULL NAME

(a) Residence. No. State Hospital # 2 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. 1 mos. 2 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED ? Unknown
(write the word)

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ? Unknown

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
about 50 Unknown

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) Unknown
 (c) Name of employer Unknown

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Unknown

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 Clerk

15. FILED 37 1929 John G. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 27 1929

17. I HEREBY CERTIFY That I attended deceased from Dec 25, 1928, to Jan 27, 1929 that I last saw alive on Jan 27, 1929, and that death occurred, on the date stated above, at 820A.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arteriosclerosis 97

CONTRIBUTORY (SECONDARY) 97B

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

DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? clinical
 (Signed) J. B. [Signature], M. D.

1/27, 1929 (Address) State Hospital # 2
 *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 Jan 30 1929

20. UNDERTAKER Webb City MO ADDRESS Rausser Funeral Service 972 Ohio

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.

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RECORD

