

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

Do not use this space.

524

1. PLACE OF DEATH

County Cape Girardeau
Township 11
City County Farm (No. 3178)

Registration District No. 125

Primary Registration District No. 3178

File No. _____
Registered No. 17
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 415 No. Middle 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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 4, 1838

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
70 9 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter
(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) Cape Girardeau

10. NAME OF FATHER

A. Aburnathy

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Cape Girardeau

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Don't know

14.

INFORMANT Mrs. R. Burgess
(Address) Cape Girardeau Mo

15.

FILED 1/18, 1929 W. Kaempfe REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY That I attended deceased from Jan 10, 1929, to Jan, 1929
that I last saw h. in alive on Jan 12, 1929, and that death occurred, on the date stated above, at about 4 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza
11B
1162
(duration) yrs. mos. da. 6
CONTRIBUTORY (SECONDARY) Stroke
(duration) yrs. mos. da. 1

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) D. G. Schubert, M. D.

1-16, 1929 (Address) Jackson 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 DATE OF BURIAL

Fairmount Cemetery Jan 18, 1929

20. UNDERTAKER ADDRESS

Walther Und. Co Cape Gir. Mo

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.

