

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

Do not use this space.

1389

1. PLACE OF DEATH

County Jackson

Registration District No. 398

Township Independence

Primary Registration District No. 3019

File No. _____

Registered No. 24

St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 305 N. Hocker St. _____

(Usual place of abode)

Ward _____

(If nonresident give city or town and State)

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

m.

4. COLOR OR RACE

Wal.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

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

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

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

(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)

PARENTS

14. INFORMANT

(Address)

15. FILED

1-22-29

F. L. Cook

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Jan. 19 1929

17.

I HEREBY CERTIFY That I attended deceased from Jan. 17 1929 to Jan. 19 1929, that I last saw him alive on Jan. 19 1929, and that death occurred, on the date stated above, at 9 P.M.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Spinal Meningitis
Meningococci
(duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. _____ mos. _____ da.

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 Spinal Fluid

(Signed) S. J. Whitte M. D.

(Address) Independence 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

Goodlawn Cem.

DATE OF BURIAL

1-22-29

20. UNDERTAKER

Hatkins Bros

ADDRESS

1729 Hyde

WRITE IN INK, 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.

