

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.

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

Do not use this space.

1739

## 1. PLACE OF DEATH

County Jackson  
Township Raw  
City Kennett

Registration District No. 509Primary Registration District No. 1002File No. 1Registered No. 331St. 2 Ward 2

## 2. FULL NAME

(a) Residence. No. 706 Locust St. 1 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 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

Colored

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

Married

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

Bessie Clarke

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

Unknown

## 7. AGE

YEARS

MONTHS

DAYS

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

31

## 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

Common Labor

## 9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Kans.

## 10. NAME OF FATHER

Wm. Clarke

## 11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Kans.

## 12. MAIDEN NAME OF MOTHER

Jennie Jefferson

## 13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

## 14.

INFORMANT Bessie Clarke  
(Address) 706 Locust St

## 15.

Filed 1-22-29 M. M. Crowe REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

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

Jan 21 1929

## 17.

I HEREBY CERTIFY, That I attended deceased from Jan 19, 1929 to Jan 21, 1929  
that I last saw him alive on Jan 21, 1929, and that death occurred, on the date stated above, at 4:45 p.m.

## THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Suppression  
Respiratory Failure  
Right-sided Failure  
(duration) yrs. mos. da.

## CONTRIBUTORY (SECONDARY)

Bronchitis  
(duration) yrs. mos. da.

## 18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

## DID AN OPERATION PRECEDE DEATH?

DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

Physical Exam  
H. M. Smith, M. D.  
122, 1929 (Address) Genl Hosp # 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

Int Muncie1-24 1929

## 20. UNDERTAKER

## ADDRESS

H. B. Moore1820618

