

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

Do not use this space.

3411

1. PLACE OF DEATH **ST. LOUIS**  
 County.....  
 Township **CARONDELET**  
 City..... (No.....) St..... Ward.....  
 Registration District No. **1123**  
 Primary Registration District No. **6248** *F*  
 File No.....  
 Registered No. **LL**

2. FULL NAME **Kessey C. James**  
 (a) Residence. No. **R. F. Off. Rk.** 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. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX **M** 4. COLOR OR RACE **W.** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (or) WIFE of **Ethel**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Oct 31, 1896**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**32 | 2 | 13**

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work **Truck Gardener**  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

**2 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Jan 14 1929**  
 17. I HEREBY CERTIFY, That I attended deceased from **Nov 6 1928**, to **Jan 14 1929**, that I last saw him alive on **Jan 14 1929**, and that death occurred, on the date stated above, at **7:30 P.M.**

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**PULMONARY TUBERCULOSIS**

CONTRIBUTORY (SECONDARY) **Empyema - Nephritis**  
 (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? **Yersinia**  
 (Signed) **Joseph Probstner**, M. D.  
 (Address) **9111 S. Broadway**

\*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.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Okla.**

PARENTS

10. NAME OF FATHER **Edward C. James**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **Mo.**

12. MAIDEN NAME OF MOTHER **Ellen Crawford**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Mo.**

14. INFORMANT **Hosp. Records**  
 (Address)

15. **Jan. 15 1929** L. C. Obrock, M.D.  
 FILED..... 19..... REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Bethania Cem.** DATE OF BURIAL **1/18 1929**

20. UNDERTAKER **Gen. Pleitsch** ADDRESS **5466 Boston Ave.**

K. 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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