

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

Do not use this space.

6551

1. PLACE OF DEATH

County Jefferson Registration District No. 399
 Township Kennett Primary Registration District No. 1
 City Kennett (No. 1617 Brooklyn Ave)

File No. _____
 Registered No. 772
 St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 1617 Brooklyn Ave St. 4 Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 2 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 Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

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

7. AGE 49 YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED Deputy Sheriff
 (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) Jefferson City (STATE OR COUNTRY) Mo

10. NAME OF FATHER Jim Hines

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

12. MAIDEN NAME OF MOTHER Portner Jones

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

14. INFORMANT Dora Hines (Address) 1617 Brooklyn Ave KC Mo

15. Filed 2-12-29 M M Corrie REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 9 1929

17. I HEREBY CERTIFY That I attended deceased from Feb 9 1929 to Feb 9 1929
 that I last saw h. alive on Feb 8 1929, and that death occurred, on the date stated above, at 3:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

813 Augusta Pectoris
Paralysis nephritis
 (duration) yrs. mos. da. 6 mos.
 CONTRIBUTORY (SECONDARY)

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? stent
 (Signed) M. D. [Signature], M. D.
11, 1929 (Address) K.C. Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Jefferson City Mo DATE OF BURIAL 2-13 1929

20. UNDERTAKER Flynn + Muenchert ADDRESS KC, Mo,

88
1
21
22

1
2

3

4
5

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

6551

1. PLACE OF DEATH

County..... Registration District No. 399 File No.....
Township..... Primary Registration District No. 1002 Registered No. 714
City K. City (No.) St. Ward)

2. FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

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

PARENTS	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)

14. INFORMANT.....
(Address)

15. FILED 2/12/29 M. M. Corum
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 9 1929
17. I HEREBY CERTIFY That I attended deceased from
19..... to 19.....
that I last saw h..... alive on 19....., and that
death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Congestive Pectoris
Paralysis of Left side
(Pulchard Paralysis) (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Paralysis Nephritis
(duration) yrs. mos. ds.

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)....., M. D.
. 19 (Address)

*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 19.....
20. UNDERTAKER	ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-6557