

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

Do not use this space.

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1. PLACE OF DEATH

County Jackson Registration District No. 399
Township W. 1st Primary Registration District No. 1002
City K.C. Mo. (No. 2643 Spruce)

File No. 779
Registered No. 779
St. _____ Ward _____

2. FULL NAME

Thomas William Speers
(a) Residence, No. 2643 Spruce St., 14 Ward. (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 male 4. COLOR OR RACE white 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) June 20 - 1871

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
57 7 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Weigh Master
(b) General nature of industry, business, or establishment in which employed (or employer) K.C. Hay dealer
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) K.C. Mo.

10. NAME OF FATHER Thos. M. Speers

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

12. MAIDEN NAME OF MOTHER Mary Ferguson

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

14. INFORMANT Mary M. Speers
(Address) 2643 Spruce Ave.

15. FILED 2-16, 1929 M. M. Brown REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 15, 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 5, 1929 to Feb 15, 1929 that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at 12:40 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

T.B. of Neck & Lungs
Tuberculosis
25
27B (duration) 40 yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED at home

IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical diagnosis

(Signed) Wm. George, M. D.

16, 1929 (Address) 2414 Clarkson

*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

Elmwood Feb. 16, 1929

20. UNDERTAKER ADDRESS

Mrs. C. L. Foster K.C. Mo.

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.

RECORDING INFORMATION THIS IS A PERMANENT RECORD

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