

23 1929
 K. R.—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.

9645

1. PLACE OF DEATH

County Buchanan
 Township St Joseph
 City St Joseph (No. Pro Meth Hosp)

Registration District No. 85
 Primary Registration District No. 1001

File No. _____
 Registered No. 350
 St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode)

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. (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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 28 1850

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
79 0 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired
 (b) General nature of industry, business, or establishment in which employed (or employer) Justice of Peace
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio Unknown

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT (Address) Hospital Record

15. FILED 14 1929 John G. Utz REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 12 1929

17. I HEREBY CERTIFY, That I attended deceased from Mar 11, 1929, to Mar 12, 1929 that I last saw h. alive on Mar 11, 1929 and that death occurred, on the date stated above, at 12:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Failure of right heart acute cholecystitis with stones.

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Chronic myocarditis
 (duration) 10 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED? POB
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) N. S. Samuel, M. D.
3/13, 1929 (Address) St Joseph 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 Oregon Deso DATE OF BURIAL 3/14 1929

20. UNDERTAKER Heleman Funeral Home ADDRESS 1208 Francis

