

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

Do not use this space.

11654

**1. PLACE OF DEATH**

County St. Louis  
Township Rivers  
City Rivers (No. ....)

Registration District No. 605  
Primary Registration District No. 5-804

File No. ....  
Registered No. ....  
St. .... Ward)

**2. FULL NAME**

James M. Clubb  
(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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED OR DIVORCED - HUSBAND OF (OR) WIFE OF Delma Clubb

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-3-1887

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
	<u>41</u>	<u>3</u>	<u>10</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Day Labour  
(b) General nature of industry, business, or establishment in which employed (or employer) .....  
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Coldwater  
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Calvin Clubb

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

12. MAIDEN NAME OF MOTHER Mary Clubb

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

14. INFORMANT Delma Clubb  
(Address) Rivers, Mo.

15. FILED 3/20/24 Mrs. C. S. Blackman  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 13 1929

17. I HEREBY CERTIFY That I attended deceased from March 6, 1929, to March 12, 1929, that I last saw him alive on March 11, 1929, and that death occurred, on the date stated above, at 4 10 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Pulmonary tuberculosis

CONTRIBUTORY (SECONDARY) None  
(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? Quinal  
(Signed) S. S. Davis, M. D.  
, 19 (Address) Parma

\*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 Clubb Memorial Home DATE OF BURIAL 3/14/29

20. UNDERTAKER J. M. Hill ADDRESS Libourne

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.

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