

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

Do not use this space.

2749  
21609

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
Township Base Primary Registration District No. 1002  
City Base (No. 1909 Base)

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward) \_\_\_\_\_

**2. FULL NAME**

Thomas M. Colough  
(a) Residence. No. 1909 Base 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 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE Col. 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) Sept 17 1920

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
8 9 3

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work School Boy  
(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) Mo

10. NAME OF FATHER James M. Colough

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

12. MAIDEN NAME OF MOTHER Georgia Miller

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

14. INFORMANT Georgia Miller (Address) 1909 Base

15. FILED 6/21/29 M. M. Crowe REGISTRAR  
asst

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 20, 1929

17. I HEREBY CERTIFY, That I attended deceased from June 13 - 1929, to June 20, 1929  
that I last saw him alive on June 20, 1929, and that death occurred, on the date stated above, at 12:45 p.m.

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

Unresolved Pneumonia  
(Kobay) 10/10  
108 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Unknown  
(duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

0 DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Physical Exam

(Signed) L. W. Bookman M. D.  
6/21/29 (Address) 2128 Vine St.

\*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 Highland DATE OF BURIAL 6/27/29

20. UNDERTAKER Nathaniel Bros ADDRESS 1729 Lyden

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.

261

2

