

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

Do not use this space.

21904

1. PLACE OF DEATH

County Knox
Township Ward
City Hurdland (No. _____)

Registration District No. _____
Primary Registration District No. _____

File No. 8
Registered No. _____
St. _____ Ward _____

2. FULL NAME John H. Black

(a) Residence. No. 20 St. W 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 **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 **Anna Black**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Sept. 19, 1883**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
85 8 29

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Farmer**
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer **Knox Co.**

9. BIRTHPLACE (CITY OR TOWN) _____
(STATE OR COUNTRY) **Missouri**

10. NAME OF FATHER **John H. Black**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) **Kentucky**

12. MAIDEN NAME OF MOTHER **Sarah Taylor**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) **Kentucky**

14. INFORMANT **Anna Black**
(Address) **Hurdland, Mo**

15. June 20, 1929 A A Sissel
Filer REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June, 18 1929**

17. I HEREBY CERTIFY, That I attended deceased from July 13, 1929 to July 18, 1929, that I last saw him alive on July 18, 1929, and that death occurred, on the date stated above, at 11:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of lips
car & throat
458

CONTRIBUTORY (SECONDARY) **Myocarditis**
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
NOT IN PLACE OF DEATH? ☒

19. DID AN OPERATION PRECEDE DEATH? 20 DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) D O Marsh, M. D.
, 19 (Address) Edina 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 DATE OF BURIAL

Erashear Mo. **June, 20 1929**
20. UNDERTAKER **J. H. Treuthart** ADDRESS **Hurdland**

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.

