

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

Do not use this space.

28725

1. PLACE OF DEATH

County St. Francois
Township St. Francois
City Near Farmington (No.)

Registration District No. 773
Primary Registration District No. 6018A

File No.
Registered No. 125
St. Ward)

2. FULL NAME Frank White

(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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
-----------------------	----------------------------------	---

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
<u>77</u>	<u>2</u>	<u>0</u>	<u>0</u>	<u>—</u>

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

9. BIRTHPLACE (CITY OR TOWN) Independence
(STATE OR COUNTRY) Iowa

PARENTS	10. NAME OF FATHER <u>Unknown</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>
	12. MAIDEN NAME OF MOTHER <u>Unknown</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>

14. INFORMANT Hospital Records
(Address) Farmington, Mo.

15. FILED 8-24-29 B. J. Robinson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 19 1929

17. I HEREBY CERTIFY, That I attended deceased from May 27 1929 to August 19 1929 that I last saw him alive on August 17 1929, and that death occurred, on the date stated above, at 10:10 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arteriosclerosis
9/16 (duration) 3 yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Dysentery - Etiology, unknown
(duration) yrs. mos. 5 ds.

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 Clinical
(Signed) C. F. Stroter, M. D.
, 19 (Address) Farmington, 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 <u>Hospital Cemetery</u>	DATE OF BURIAL <u>Aug 21 19 29</u>
20. UNDERTAKER <u>Hospital No. 4.</u>	ADDRESS <u>Farmington</u>

WRITE FAIRLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

74
30
10/21

2

31

