

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

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

Do not use this space.

30470

1. PLACE OF DEATH

County Dunklin
Township
City Malden (No.)

Registration District No. 289
Primary Registration District No. 4173

File No.
Registered No. 52
St. Ward)

2. FULL NAME

Wm H. Alexander
(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 Hannah Alexander
6. DATE OF BIRTH (MONTH, DAY AND YEAR)
7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or min.
66 2 17

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Machinist
(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) St. Francois Co. Mo.

10. NAME OF FATHER

John Alexander

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Don't Know

12. MAIDEN NAME OF MOTHER

Mary Struppe

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Don't Know

14.

INFORMANT Mrs. W. H. Alexander
(Address) Malden Mo.

15.

FILED 9-18-29 SE Mitchell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 18 19 29

17. I HEREBY CERTIFY, That I attended deceased from Sept 14 1929 to Sept 18 1929
that I last saw him alive on Sept 17 1929, and that death occurred, on the date stated above, at 12:10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acidosis - non diabetic
69 About
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (SECONDARY)

Unknown
(duration) yrs. mos. 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? Urinary, Ludwig's

(Signed) Homer Beal M. D.

9-18-1929 (Address) Malden 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

St Louis Mo. 9-21 19 29

20. UNDERTAKER

ADDRESS

H. L. Craig Malden

PSYCHIATRIC HOSPITAL
WORK IS VERY IMPORTANT

W. B. - Every Item of
OR OR DEATH
action should

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Lumpkin

Registration District No. 289

File No.

Township Malden

Primary Registration District No. 4173

Registered No. 5-2

City Malden (No. 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 M (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 1, 1863

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
66 2 17

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT (Address)

15.

FILED 9/19/1927

S. E. Mitchell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 18 1927

17. I HEREBY CERTIFY That I attended deceased from 19..... to 19..... that I last saw him alive on 19..... and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) M. D.

, 19 (Address)

*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

20. UNDERTAKER

ADDRESS

None of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-30470