

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

Do not use this space.

31090

1. PLACE OF DEATH

County Jackson
Township Prairie
City (No.)

Registration District No. 400
Primary Registration District No. 255 PD

File No. _____
Registered No. 178
St. _____ Ward _____

2. FULL NAME

Richard E. Lackey

(a) Residence No. Jackson Home 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 single
(write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF single
6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-21-1929
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
60 7 19

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) unknown
(c) Name of employer unknown

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

PARENTS
10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) unknown
(STATE OR COUNTRY) unknown
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) unknown
(STATE OR COUNTRY) unknown

14. INFORMANT J. W. Hostetter
(Address) Jackson Coffey

15. Sept 25 1929 REGISTRAR [Signature]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 21 - 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Sept 21, 1929, that I last saw him alive on Sept 20, 1929 and that death occurred, on the date stated above, at 6:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

chronic myocarditis
936900
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Generalization
(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? Clinical
(Signed) [Signature], M. D.

9/22, 1929 (address) Independence 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 Hydrilla College of Osteopathy
1212 Quincy Kennett Mo DATE OF BURIAL Sept 25 1929

20. UNDERTAKER Mo State Anatomical Society, Kennett Mo ADDRESS K.E. Mo

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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