

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

Do not use this space.

31104

**1. PLACE OF DEATH**

County Jasper  
Township Marion  
City Carthage (No. ....)

Registration District No. 408  
Primary Registration District No. 8020

File No. ....  
Registered No. ....  
St. .... Ward

**2. FULL NAME**

Henry C. Bloom

(a) Residence. No. 216 N. Maple 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 Susan Bloom

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 21 1849

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
78 1 22

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

9. BIRTHPLACE (CITY OR TOWN) Augustville  
(STATE OR COUNTRY) Penn.

10. NAME OF FATHER Daniel Bloom

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

12. MAIDEN NAME OF MOTHER Lydial Camp

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

14. INFORMANT Susan Bloom  
(Address) Carthage 216 N. Maple

15. FILED 9/16, 1929 Cliff Leitch  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 13 1929

17. I HEREBY CERTIFY, That I attended deceased from 9-7, 1929, to 9-10-29, 1929, that I last saw him alive on 9-13, 1929, and that death occurred, on the date stated above, at 6:30 PM.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Chronic Bright's

131  
1290  
(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 .....

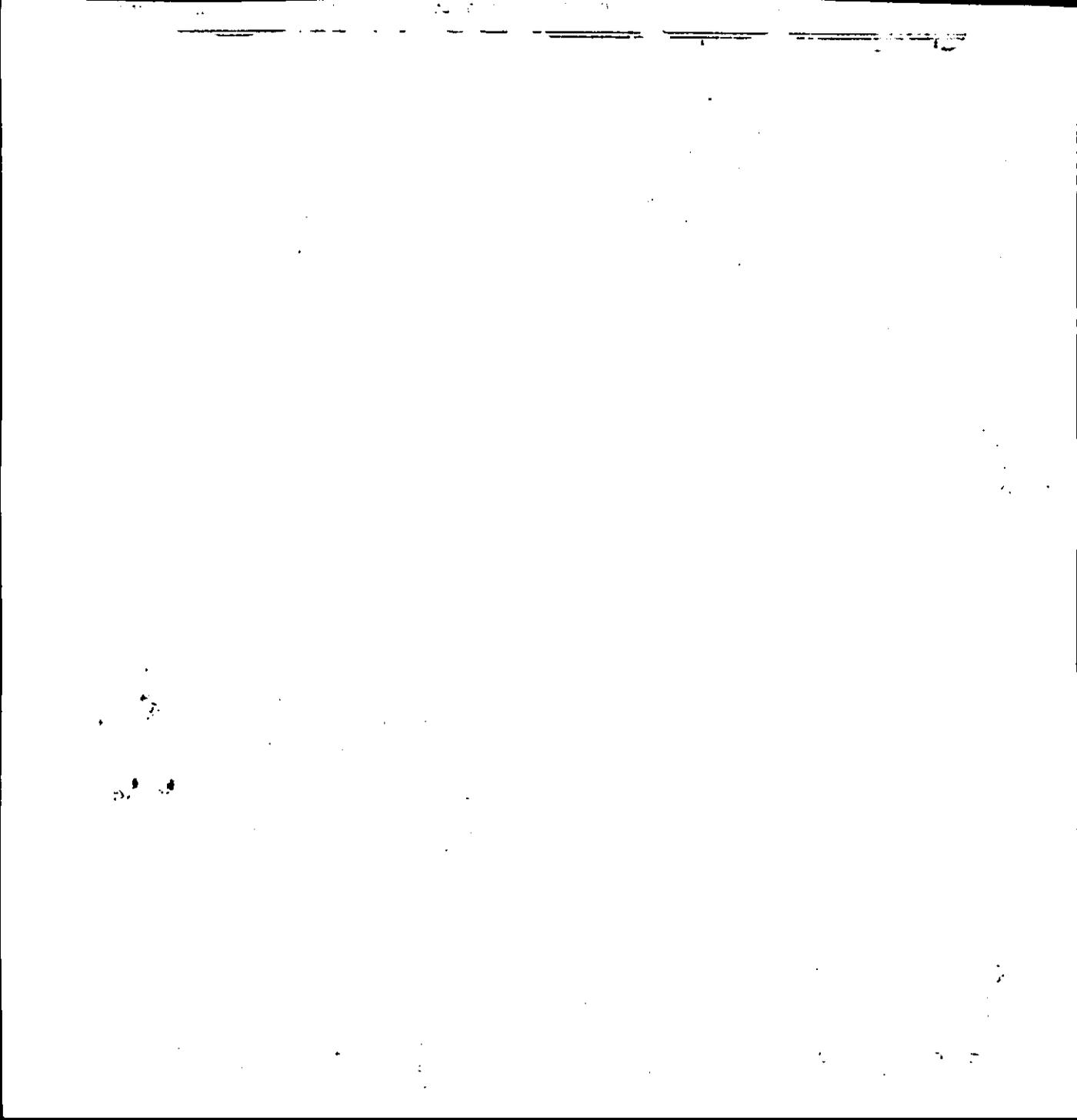
WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) H. E. Kaker, M. D.  
. 19 (Address) Carthage 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 Park Cemetery DATE OF BURIAL Sept 17 1929

20. UNDERTAKER Knell Mortuary ADDRESS Carthage



**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 Gasconade  
Township Cherokee  
City Cherokee (No. .... St. .... Ward)

Registration District No. 408  
Primary Registration District No. 3020

File No. ....  
Registered No. ....

**2. FULL NAME**

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 21 - 1879

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
79 10 8 22

**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 9/30 1927 C. M. DeChau REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 13 1929

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

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

CONTRIBUTORY (SECONDARY)

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

SUPPLEMENTARY

hollis