

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

Do not use this space.

Dr. Conrad
37982

File No. _____
Registered No. *106* _____
St. _____ Ward) _____

1. PLACE OF DEATH

County *Jefferson* Registration District No. *65-1*
Township *Little Cairn* Primary Registration District No. *1-862*
City _____ No. _____ St. _____ Ward) _____

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

Female white Widow

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

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

8-7-1865

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

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8. OCCUPATION OF DECEASED

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

St. Ph.

(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)

Leaves
Henry Spiker

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ill.

12. MAIDEN NAME OF MOTHER

Carline Head

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

D. H.

14. INFORMANT

(Address)

Eloy Adams
Carlyle Hills

15. FILED

Dec 7, 1929

Ada Martin

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *11-15* 19*29*

17. I HEREBY CERTIFY, That I attended deceased from *11-12*, 19*29*, to *11-15*, 19*29*, that I last saw him alive on *11-15*, 19*29*, and that death occurred, on the date stated above, at *3-30* p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

asthma Chronic

CONTRIBUTORY (SECONDARY)

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? *none*

(Signed) *J. R. Coyne* M. D.

Nov. 11, 1929 (Address *Carlyle Hills*)

*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

Maple Cemetery

11-16-1929

20. UNDERTAKER

Carlyle

J. R. Coyne

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PRECEDENCE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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