

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

Do not use this space.

41023

1. PLACE OF DEATH

County Jackson

Registration District No. 409

File No. _____

Township Summit

Primary Registration District No. 4235

Registered No. 157

City Summit (No. _____)

St. _____

Ward) _____

2. FULL NAME

Pomus Baston

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

Negro

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

Single

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

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

May-14-1896

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1

33

7

12

day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

Labourer

(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)

Glasgow

Mo.

10. NAME OF FATHER

Charley Baston

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

Glasgow

Mo.

12. MAIDEN NAME OF MOTHER

Charlottesville Brown

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

Glasgow

Mo.

14. INFORMANT (Address)

R. B. Fields

Summit Mo

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

12/26 1929

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:

Pulmonary tuberculosis

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. 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.

20. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Summit Cemetery

12-26-29

21. UNDERTAKER

Fields James Ed

ADDRESS

Summit Mo

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Am. 10/10/20