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

Do not use this space.

227

File No. 77

Registered No. 70

1. PLACE OF DEATH

County: Buchanan

Township: X

City: St Joseph (No. ..... St. ..... Ward)

Registration District No. 85

Primary Registration District No. 1001

2. FULL NAME: George W. Shomblin

(a) Residence. No. State Hosp # 2 St., ... Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 11 mos. 8 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*): married.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Unk 1884

7. AGE: YEARS 45 | MONTHS Unknown | DAYS | IF LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

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

(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): Unknown

PARENTS

10. NAME OF FATHER: James D. Shomblin

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

12. MAIDEN NAME OF MOTHER: Price, Eveline

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

14. INFORMANT: Mrs Clara Shomblin.
(Address) Coates House. K. C. Mo.

15. FILED Jan 18, 1930 John G. Ott REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 15 1930

17. I HEREBY CERTIFY, That I attended deceased from March 25, 1929 to Jan 15, 1930 that I last saw him alive on Jan 15, 1930 and that death occurred, on the date stated above, at 10 25 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tubercular Peritonitis.

3 5

..... (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? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical.

(Signed) J. R. Burch, M. D.

1/15/1930 (Address) State Hosp # 2

*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: State Hosp #2 Bem | DATE OF BURIAL: Jan 20 1930

20. UNDERTAKER: Heemann Funeral Home | ADDRESS: 1946 Colburn

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

V. S. No. 2.

NGA