

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.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County BuchananRegistration District No. 85Township LathropPrimary Registration District No. 1001City St. Joseph(No. State Hospital #2)File No. 250Registered No. 93

St. _____

Ward _____

2. FULL NAME

(a) Residence. No. State Hosp #2 St. Hosp Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs. 8

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)

widower

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

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

Unknown 84-7

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1

day, _____ hrs.

or _____ min.

83 Unknown

8. OCCUPATION OF DECEASED

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

Salvage

(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

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

14.

INFORMANT

State Hosp #2

Address

St Joseph

15.

FILED

23 1930John G. St

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Jan 22 1930

17.

I HEREBY CERTIFY, That I attended deceased from

May 21 1929, to Jan 22 1930, 1930that I last saw him alive on Jan 22 1930 and thatdeath occurred, on the date stated above, at 5-0-4 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage45-899

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

arterio sclerosis(duration) _____ yrs. 8 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) D. G. D. D. M. D.

1-22-1930 (Address)

State Hosp

*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

St. Joseph Cemetery Jan 24 1930

20. UNDERTAKER

ADDRESS

E. C. Eidenfaden 602 So. 10th

