

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

Do not use this space.

253

1. PLACE OF DEATH

County Buchanan Registration District No. 85
Township St Joseph Primary Registration District No. 1001
City St Joseph, Mo (No. Hayes Hospital)
Baptist

File No. _____
Registered No. 96
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 913 North 14th 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widow</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Unknown 1847</u>				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
	<u>83</u>	<u>Unknown</u>		
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) <u>Unknown</u>				
PARENTS	10. NAME OF FATHER <u>Unknown</u>			
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>			
	12. MAIDEN NAME OF MOTHER <u>Unknown</u>			
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>			
	14. INFORMANT <u>H. A. Hope</u>			
15. FILED <u>Jan 23 1930</u> REGISTRAR <u>John G. W.</u>				

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) January 23, 1930
17. HEREBY CERTIFY, That I attended deceased from Jan 20, 1930, to Jan 23, 1930
that I last saw him alive on Jan 22, 1930, and that death occurred, on the date stated above, at 11:10 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Quarrelsome
1867 (Bonalie)
1948
10718 (duration) yrs. mos. 2 ds.
CONTRIBUTORY (SECONDARY) fracture neck of femur
from fall in his own yard (duration) yrs. mos. ds.

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? clinical
(Signed) Floyd H. Jensen M. D.
1/23, 1930 (Address) 212 1/2 E. 13th

*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 Galbiton, Missouri DATE OF BURIAL Jan 23, 1930
20. UNDERTAKER Shuman Funeral Home ADDRESS 1946 Colham

WHITE PAPER, WITH UNFOLDING TABS--THIS IS PERMANENT RECORD

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.

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