

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

Do not use this space.

1358

**1. PLACE OF DEATH**

County Jackson  
Township Tau  
City Kanran City

Registration District No. 399  
Primary Registration District No. 1002  
(No. Mercy Hosp.)

File No. 350  
Registered No. 350  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. 1315 Landalet St. Ward. 12

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mes. ds. How long in U. S., if of foreign birth? yrs. mes. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED, (write the word) Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 11 - 1920

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>13</u>	<u>7</u>	<u>11</u>	<u>11</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) Student  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) K.C., Mo.  
(STATE OR COUNTRY)

10. NAME OF FATHER James Virgin

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

12. MAIDEN NAME OF MOTHER Angie de Sta

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

14. INFORMANT Mr. James Virgin  
(Address) 1315 Landalet

15. FILED 1/24 1930 M. M. Crowe  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1 - 22 1930

17. I HEREBY CERTIFY, That I attended deceased from 12-25, 1929, to 1-22, 1930 that I last saw him alive on 1-23, 1930, and that death occurred, on the date stated above, at 2:35 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

108  
1107 Lobar Pneumonia  
Empyema  
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (SECONDARY) Lobar Pneumonia  
(duration) yrs. 1 mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED 1010  
IF NOT AT PLACE OF BIRTH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) D. W. Crowe M. D.

1/22 1930 (Address) Mercy 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 St. Washington DATE OF BURIAL Jan 25 1930

20. UNDERTAKER Rose Henderson ADDRESS City

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.

