

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

Do not use this space.

1726

1. PLACE OF DEATH

County Cape Girardeau
Township Washington
City Washington (No. _____) St. _____ Ward _____

Registration District No. 461
Primary Registration District No. 3024

File No. 7
Registered No. _____

2. FULL NAME

(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

3. SEX Male 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Don't know

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>About 80</u>				

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Coal Miner
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Richmond
(STATE OR COUNTRY) Pa

10. NAME OF FATHER Don't know

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

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT Thalmers M Holmes
(Address) Lexington MO

15. FILED Jan 23 19 30 J. D. Cape
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 Jan 20, 1930, to Jan 22, 1930, that I last saw him alive on Jan 21, 1930, and that death occurred, on the date stated above, at 3:25 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Lobar Pneumonia
108

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

CONTRIBUTORY (SECONDARY) none
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED? at home
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? same
(Signed) A. D. Ball
Jan 23 19 30 (Address) Lexington MO

*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 Lexington MO DATE OF BURIAL Jan 24 19 30

20. UNDERTAKER Ernest Teget ADDRESS Lexington

WRITE PLAINLY, WITH UNFADING INK---THIS IS A 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.

FILED 19 1929

