

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

Do not use this space.

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 4907
 Township Saw Primary Registration District No. 557
 City Cassidy (No. Waverly Park Hospital) (Ward)

2. FULL NAME

(a) Residence No. Coates Home St. W Ward. W
 (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

1. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF 1

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown
 7. AGE Years 59 MONTHS _____ DAYS _____
 If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Deputy Auditor
 (b) General nature of industry, business, or establishment in which employed (or employer) Fraternities Order of Eagles
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Conn

10. NAME OF FATHER Gray

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

12. MAIDEN NAME OF MOTHER Dont know

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

14. INFORMANT (Address) W O Central

15. FILED 7/6, 1930 M. M. Grove REGISTRAR

4 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) February 5, 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Feb 5, 1930 that I last saw him alive on Feb 5, 1930 at 5:30 PM death occurred, on the date stated above, at _____

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Mitral Insufficiency
Paralysis of Right Foot & Toe
Papainic

(duration) _____ yrs. _____ mos. 5 da.

CONTRIBUTORY (SECONDARY) Diabetes Mellitus -

Brain History (duration) 15 yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED 57 59

IF NOT AT PLACE OF DEATH. 8 DID AN OPERATION PRECEDE DEATH? 57 59 DATE OF 9 30

WAS THERE AN AUTOPSY? 90

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) D. A. Mabey, M. D.

7/6, 1930 (Address) 700 Summit Ave

*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 New Haven Conn DATE OF BURIAL 1930

20. UNDERTAKER F O Donnell Co ADDRESS 3036 Edwy

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.

37 2 251

4017 Bell