

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

Do not use this space.

7409
~~7401~~

1. PLACE OF DEATH

County Stoddard
Township Castor
City Castor

Registration District No. 837
Primary Registration District No. 6099

File No. _____
Registered No. _____
St. _____ Ward) _____

2. FULL NAME

R. H. Case

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

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

Russ Case

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

2-12-1863

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

67

8. OCCUPATION OF DECEASED

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

(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) Kansas

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kansas

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Not known

14.

INFORMANT Harold Case
(Address) Bloomfield, Mo.

15.

Bl. 28 30 W. W. Ford
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-12 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 25, 1930, to Feb 12, 1930
that I last saw h. _____ alive on _____, 19____ and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Senile paraplegia of Pook

99-0
1510 (duration) yrs. 7 mos. ds.

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

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) E. W. Briney, M. D.
. 19 (Address) Bloomfield, 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 Bloomfield, Mo. DATE OF BURIAL 2-15 1930

20. UNDERTAKER J. A. Childs Bloomfield ADDRESS _____

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.

MA 9 28 1930

