

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

Do not use this space.

7760

1. PLACE OF DEATH

County Buchanan
Township St. Joseph
City St. Joseph

Registration District No. 85
Primary Registration District No. 1001

File No. _____
Registered No. 302
St. _____ Ward _____

2. FULL NAME

William Posters
(a) Residence No. State Hosp # 2 St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 5 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) about 1856

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>74</u>	<u>Months</u>			

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) Farmwork
(c) Name of employer Self

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

PARENTS	10. NAME OF FATHER <u>Unknown</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Unknown</u> (STATE OR COUNTRY) <u>Unknown</u>
	12. MAIDEN NAME OF MOTHER <u>Unknown</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Unknown</u> (STATE OR COUNTRY) <u>Unknown</u>

14. INFORMANT Records St. Hosp # 2
Address State Hosp. St. Joseph, Mo.

15. FILED 11 1930 John C. H. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 10, 1930

17. I HEREBY CERTIFY, That I attended deceased from Oct 10, 1928, to March 10, 1930
that I last saw him alive on March 10, 1930, and that death occurred, on the date stated above, at 7:40 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
82A (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 74 (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?
(Signed) J. R. Bunch, M. D.
3/10/1930 (Address) State Hosp # 2

*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 <u>Oregon, Mo.</u>	DATE OF BURIAL <u>Mar 12 1930</u>
20. UNDERTAKER <u>L. V. Lehmer</u>	ADDRESS <u>Oregon, Mo.</u>

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.

APR 23 1930

