

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

Do not use this space.

8642

1. PLACE OF DEATH
 County Jackson Registration District No. _____ File No. _____
 Township Kaw Primary Registration District No. _____ Registered No. _____
 City Amos City (No. General Hospital #2) St. _____ Ward _____

2. FULL NAME Lee London
 (a) Residence No. 3620 S. 8th 630 W. 8 (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 40 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 ed
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 20-1858
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
74 4 12
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Common Laborer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Tenn.
 (STATE OR COUNTRY) _____
 10. NAME OF FATHER Unknown.
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Tenn.
 (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER Unknown
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Tenn.
 (STATE OR COUNTRY) _____

14. INFORMANT Secy of Chrch
 (Address) City Hospital #2
 15. FILED 3/6 19 30 M. M. Crowe
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 2 19 30
 17. I HEREBY CERTIFY, That I attended deceased from 2-25-30, 1930 to 3-1-30, 1930, that I last saw him alive on 3-1-30, 1930, and that death occurred, on the date stated above, at 7:20 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Eritrotoxi.
122A
129

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

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF BIRTH _____
 DID AN OPERATION PRECEDE DEATH? Yes DATE OF 2/25/30
 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) A. M. Smith, M. D.
3/3 19 30 (Address) City Hospital #2

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY; and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Blue Ridge Burial DATE OF BURIAL Mar. 8 1930
 20. UNDERTAKER West, Updegraff & Co ADDRESS 1600 E. 9th

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.

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