

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

Do not use this space.

9030

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Kear Primary Registration District No. 1002
City Kear (No. 1216) Warfield St. _____ Ward _____

File No. _____
Registered No. 1442

2. FULL NAME

(a) Residence. No. 1216 Warfield St. 2 Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>negro</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF <u>Maude Jones</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Jan 15 1890</u>		
7. AGE	YEARS <u>40</u>	MONTHS <u>2</u>
	DAY <u>15</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>janitor</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____		

9. BIRTHPLACE (CITY OR TOWN) Warrensburg
(STATE OR COUNTRY) mo

PARENTS	10. NAME OF FATHER <u>Robert Jones</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Warrensburg</u> (STATE OR COUNTRY) <u>mo</u>
	12. MAIDEN NAME OF MOTHER <u>Mary Cooper</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Montreat</u> (STATE OR COUNTRY) <u>mo</u>

14. INFORMANT Robert Jones (Father)
(Address) 1216 Warfield ave

15. FILED 3/31, 1930 M. M. Croome
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-29-30

17. Deputy Coroner
I HEREBY CERTIFY, That I attended deceased from _____ 19____, to _____ 19____, that I last saw him _____ alive on _____ 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myocarditis
Chronic Interstitial Nephritis
(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) Nephritis (duration) _____ yrs. _____ mos. _____ ds.

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

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS autopsy
(Signed) Deputy Coroner M.D.
(Address) _____

*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 Blue Ridge Lawn Cemetery DATE OF BURIAL 4-1-30
20. UNDERTAKER Flippin + Greenstreet ADDRESS Kear

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.

266

