

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

Do not use this space.

9073-2

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
Township Leeds Primary Registration District No. 1002  
City Blue No. Leeds Hospital St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. P 2508  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** maere George

(a) Residence. No. 1216 Guisette St. 9 Ward T. B. Hospital T. B. Annex  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX <u>male</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Single</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Feb 21 - 1904</u>		
7. AGE <u>25</u> YEARS	MONTHS	DAYS
<u>25</u>		<u>11</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Auto mechanic</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-2-1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 4 - 1929, 19\_\_\_\_, to March 2 - 1930, 19\_\_\_\_ that I last saw h. alive on 3-2-1930, and that death occurred, on the date stated above, at 7:10 p.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Acute Pulmonary Tuberculosis  
334 (duration) 0 yrs. 9 mos. 0 ds.

CONTRIBUTORY (SECONDARY) None (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

10. NAME OF FATHER maere Andy

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

12. MAIDEN NAME OF MOTHER Johnson Mary

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

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

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Laboratory  
(Signed) Edwin H. Lee, M. D.

M413, 1930 (Address) 1830 Vine St K.C. 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.

14. INFORMANT Leeds T. B. Hospital  
(Address) Leeds Mo.

15. FILED 6/6 1930 M. M. Grover  
REGISTRAR  
Asst

19. PLACE OF BURIAL, CREMATION, OR REMOVAL R. C. Western Dental Col DATE OF BURIAL 5/21/30

20. UNDERTAKER West Appleton Inc ADDRESS 1007 W

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.

30  
1-10-30  
2-6-4/25/30

1216 Gram. 366

Vic. 1657

Mont. 1657