

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

Do not use this space.

9190

1. PLACE OF DEATH

County Jasper Registration District No. 417
 Township _____ Primary Registration District No. 3021
 City Webb City (No. _____) St. _____ Ward _____

File No. _____
 Registered No. 41

2. FULL NAME

T. H. Komans
 (a) Residence No. 423 W. Broadway St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. 1 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 white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs Mary J. Komans

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 4, 1855

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
74 8 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Justice of the Peace
 (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) Penn.

PARENTS

10. NAME OF FATHER Don't know

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

12. MAIDEN NAME OF MOTHER Don't know

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

14. INFORMANT Mrs. Mary J. Komans
 (Address) Webb City, Mo.

15. FILED 3/27 1930 A. M. Storvick
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 26 1930

17. I HEREBY CERTIFY That I attended deceased from March 26 1930 to March 26 1930 that I last saw him alive on March 26 1930, and that death occurred, on the date stated above, at March 26 1930 9:15 pm

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage -
82A

CONTRIBUTORY (SECONDARY) 74A
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

18 DID AN OPERATION PRECEDE DEATH DATE OF _____

18 WAS THERE AN AUTOPSY _____

18 WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) T. J. Ingle, M. D.

3/27 1930 (Address) Webb City 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 Webb City DATE OF BURIAL Mar. 27 1930

20. UNDERTAKER Steele Und. Co. ADDRESS Webb City, Mo.

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 30 1930

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