

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

Do not use this space.

11268

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **1003**

File No.
Registered No. **3464**
St. Ward.....

2. FULL NAME

(a) Residence No. **2319 Pine St.** St. **9** Ward.....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 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 **Colored** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **John**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **March 1901**

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
42	—	—	—	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Labore**
(b) General nature of industry, business, or establishment in which employed (or employer) **Old jobs**
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) **ark**

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14. INFORMANT (Address) **John H. ... Deputy Coroner**

15. REGISTRAR (Address) **Ray C. ...**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **March 27 1930**

17. **No Physician in attendance**
I HEREBY CERTIFY, That I attended deceased from

19..... to..... 19.....
that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at **400** m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

82A
Cerebral Haemorrhage
Non-traumatic yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

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

(Signed) **John H. ... M.D.**

4/7, 1930 (Address) **Deputy Coroner**

*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

DATE OF BURIAL

Wattersfield 4-8-1930

20. UNDERTAKER

ADDRESS

Lincoln Jones 3129 New

WRITE FULLY, 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.

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