

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

Do not use this space.

12915

1. PLACE OF DEATH

County Richmond
Township W. C. No.
City W. C. No. (No. old city Hoop)

Registration District No. 399
Primary Registration District No. 1122

File No. 1844
Registered No. 1844
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 1012 W. C. No. St. apt C Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</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>Mary L. Matthew</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>3-15-1890</u>		
7. AGE	YEARS	MONTHS
<u>40</u>	<u>1</u>	<u>11</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Ch. Cleaner - K. Edm.</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>121B</u> (c) Name of employer		

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

PARENTS

10. NAME OF FATHER <u>Peter Matthews</u>
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>La.</u>
12. MAIDEN NAME OF MOTHER <u>B. Tubbo</u>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>La.</u>

14. INFORMANT George Chapp
(Address) Gen. Hospital # 2

15. FILED 4/28/30 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-26-1930

17. I HEREBY CERTIFY, That I attended deceased from 4-19, 1930, to 4-26, 1930 that I last saw him alive on 4-26, 1930, and that death occurred, on the date stated above, at 6:05 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Appendiceal Abscess
Post-operative shock
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 1173
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED 101 W. C. No. (apt. C)

1 DID AN OPERATION PRECEDE DEATH? Yes DATE OF 4-24-30

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? operation
(Signed) Dr. [Signature], M. D.

4-26, 1930 (Address) Kansas 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 <u>Camp Oak</u>	DATE OF BURIAL <u>4-28-1930</u>
20. UNDERTAKER <u>Wm. A. Fickler</u>	ADDRESS <u>1212 1/2 W. C. No.</u>

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.

WHITE PLAIN, WITH UNFADING INK—THIS IS A PERMANENT RECORD

24
2

11/1

