

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

Do not use this space.

13363

1. PLACE OF DEATH

County Mississippi
Township St James
City _____ (No. _____)

Registration District No. 576
Primary Registration District No. 5763

File No. 154
Registered No. 40
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ 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. 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

Low Thompson

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

April 5, 1877

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>58</u>		<u>14</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. farmer
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Allen Co. Ky.

(STATE OR COUNTRY)

10. NAME OF FATHER

don't know

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

don't know

12. MAIDEN NAME OF MOTHER

Betty Stone

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ky

14. INFORMANT

(Address) Miss Squantha Borders
Esthler St. Memphis

15. FILED

April 30, 1930 S. M. Hodges
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

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

April 19, 1930

17.

I HEREBY CERTIFY, That I attended deceased from April 7, 1930 to April 19, 1930 that I last saw him alive on April 17, 1930, and that death occurred, on the date stated above, at abt 7:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza
11A
109
114 B (duration) yrs. mos. 14 ds.
CONTRIBUTORY Lobar Pneumonia
(SECONDARY) with abscess formation (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

at home
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? no DATE OF 2
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) George W. Whitaker, M. D.
. 19 (Address) East Prairie 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

Oak Grove

DATE OF BURIAL

4/20, 1930

20. UNDERTAKER

Irma Sheelby

ADDRESS

East Prairie

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.

