

MAY 27 1930

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

Do not use this space

13686
12096

1. PLACE OF DEATH

 County Randolph
 Township Dugessick
 City Moberly

 Registration District No. 735
 Primary Registration District No. 3034

 File No. _____
 Registered No. 329
 St. _____ Ward)

2. FULL NAME

 (a) Residence. No. Hate No 6 St. Hate No. 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. 10 da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

 3. SEX M. 4. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) unknown

 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF 7
6. DATE OF BIRTH (MONTH, DAY AND YEAR) unknown
 7. AGE 3 YEARS MONTHS DAYS IF LESS than 1 day, _____ hr. or _____ min.

8. OCCUPATION OF DECEASED

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

 9. BIRTHPLACE (CITY OR TOWN) unknown.
 (STATE OR COUNTRY)
10. NAME OF FATHER unknown.
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) unknown
 (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER unknown
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) unknown
 (STATE OR COUNTRY)

 14. INFORMANT _____
 (Address)

 15. FILED 5-8 1930 Dr. Tho. J. Fleming
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 29 1930
 17. I HEREBY CERTIFY, That I attended deceased from April 19, 1930, to April 29, 1930, that I last saw h. alive on April 29, 1930, and that death occurred, on (the date stated above, at) 4 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1930 / 10 / 29
LABOR PNEUMONIA
 (duration) _____ yrs. mos. 10 da.

 CONTRIBUTORY (SECONDARY) Myocarditis
 (duration) _____ yrs. mos. da.

 18. WHERE WAS DISEASE CONTRACTED hospital Moberly, Mo.
 IF NOT AT PLACE OF DEATH.

 19. DID AN OPERATION PRECEDE DEATH. No DATE OF _____

 WAS THERE AN AUTOPSY? No

 WHAT TEST CONFIRMED DIAGNOSIS? Clinical symptoms only
 (Signed) H. C. Griffiths, M. D.

5-8-1930 (Address) Moberly 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

Shipped to Anatomical DATE OF BURIAL _____ 19 _____

20. UNDERTAKER

Bureau at Columbia ADDRESS _____
Missouri 5/8/30

WRITE PLAINLY, 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.

