

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

Do not use this space.

15532

**1. PLACE OF DEATH**

County Cape Girardeau Registration District No. 125  
Township 11 Primary Registration District No. 3009  
City 11 (No. 11) St. Francis Hospital

File No. ....  
Registered No. 412 St. .... Ward)

**2. FULL NAME**

Chester Eugene Floyd

(a) Residence No. R.F.D. #3 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 1 - 1924

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
10 27

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. Child 30  
(b) General nature of industry, business, or establishment in which employed (or employer) 24  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Cape Girardeau  
(STATE OR COUNTRY) Mo

10. NAME OF FATHER Albert Floyd

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Cape Girardeau  
(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER Edith Smith

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Cape Girardeau  
(STATE OR COUNTRY) Mo

14. INFORMANT Myself Albert Floyd  
(Address) R.F.D. #3

15. FILED 5/29/30 W. K. Sample REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May - 28 1930

17. I HEREBY CERTIFY, That I attended deceased from May 24 1930, to May 28 1930 that I last saw h. alive on May 28 1930, and that death occurred, on the date stated above, at 10 m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Acute Miliary tuberculosis  
following a localized  
ph. opical tuberculosis  
4 (duration) yrs. mos. ds.  
CONTRIBUTORY Tuberculosis meningitis  
(SECONDARY) (duration) yrs. mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH St. Francis Hospital

DID AN OPERATION PRECEDE DEATH? DATE OF .....  
WAS THERE AN AUTOPSY? Yes  
WHAT TEST CONFIRMED DIAGNOSIS P.M. Funtunig etc  
(Signed) Carl W. Smith M. D.  
. 19 (Address)

\*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  
McClain Chapel Cem. 5-30 1930

20. UNDERTAKER ADDRESS  
Haman's Funeral Home Cape Girardeau

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.

