

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

Do not use this space.

15628

1. PLACE OF DEATH

County Belair
Township 7th River
City East Spencerville (No. _____) St. _____ Ward _____

Registration District No. 198
Primary Registration District No. 3011

File No. _____
Registered No. 55

2. FULL NAME

Jayne — Walter L.

(a) Residence No. _____ St. _____ Ward. Spencer Grove
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OF RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) January 16 1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
61 4 13

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Spencer Grove

10. NAME OF FATHER David T. Jayne

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) New York

12. MAIDEN NAME OF MOTHER Belair, Henrietta

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) New York

14. INFORMANT F. E. Jayne
(Address) Spencer Grove

15. FILED 9/30 1930 J. W. Crover REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-29-1930

17. I HEREBY CERTIFY, That I attended deceased from May 20 1930, to May 29 1930. That I last saw him alive on May 29 1930, and that death occurred, on the date stated above, at 3:35 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(1) Acute Nephritis
131
132A
132B (duration) _____ yrs. _____ mos. 2 ds.
CONTRIBUTORY (SECONDARY) Cystitis - Chronic Interstitial
Nephritis - High blood pressure (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 _____

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS (Signed) W. H. Mitchell M.D.

(Address) Ball Sanitarium
Spencer Grove, 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 Spencer Grove, Douthett DATE OF BURIAL _____

20. UNDERTAKER Hubert Hope Eversing ADDRESS _____

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.

JUN 24 1930

