

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

Do not use this space.

16392

**1. PLACE OF DEATH**

County Jackson  
Township Scott  
City Kennett City (No. Kennett City General Hospital)

Registration District No. 399  
Primary Registration District No. 1602

File No. \_\_\_\_\_  
Registered No. 2301 (Ward)

**2. FULL NAME**

(a) Residence. No. 2225 Passat St. 4 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<br><u>male</u> | 4. COLOR OR RACE<br><u>white</u> | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)<br><u>married</u> |
|-----------------------|----------------------------------|--|

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) not known

|        |                    |                    |                 |  |
|--------|--------------------|--------------------|-----------------|--|
| 7. AGE | YEARS<br><u>52</u> | MONTHS<br><u>—</u> | DAY<br><u>—</u> | If LESS than 1 day, _____ hrs. or _____ min. |
|--------|--------------------|--------------------|-----------------|--|

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) not known

10. NAME OF FATHER not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) not known

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) not known

14. INFORMANT Beard Clark  
(Address) Kennett City, Kennett Hosp

15. FILED 9/1 1930 M. M. Crout REGISTRAR  
Asst

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-31-1930

17. I HEREBY CERTIFY, That I attended deceased from 5-24-1930, 1930, to 5-31-1930, 1930 that I last saw him alive on 5-31-1930, and that death occurred, on the date stated above, at 2:30 P.M.

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

Chronic Pulmonary Tuberculosis

23A

CONTRIBUTORY (SECONDARY) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS (Signed) P. B. Williams, M. D.

5-31-1930 (Address) Supt. K. G. Gen'l Hosp

\*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 Mt. Carmel DATE OF BURIAL 6-1-1930

20. UNDERTAKER J. P. Louis ADDRESS Kennett City, Mo

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.

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PARENTS

