

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

Do not use this space.

19024

1. PLACE OF DEATH
 County Dent Registration District No. 266 File No. _____
 Township _____ Primary Registration District No. 4164 Registered No. 120
 City Salem Mo (No. _____) St. _____ Ward _____

2. FULL NAME Joseph Milton McSpadden
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

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) Dec 29 / 1839

7. AGE YEARS 70 MON. 3 DAYS 6 If LESS than 1 day, _____ hrs. or _____ min.

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) Dent Co Mo
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Dent Co Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER Moses Milton McSpadden

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

12. MAIDEN NAME OF MOTHER Julia Ann Miskap

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Washington Co Mo
 (STATE OR COUNTRY)

14. INFORMANT Miss Emma McSpadden
 (Address)

15. FILED 6/6 1930 W E Reed REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 4 1930

17. I HEREBY CERTIFY, That I attended deceased from May 30, 1930, to June 3, 1930, that I last saw him alive on June 3, 1930, and that death occurred, on the date stated above, at 1:30 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Interstitial Nephritis
(Chronic)

151 (duration) 3 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 1290 (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? NO

WHAT TEST CONFIRMED DIAGNOSIS? Urinal Signs
 (Signed) D. C. E. Matlock & H. G. Dixon, M. D.
 , 19 _____ (Address) St Louis & Salem 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 McSpadden Farm DATE OF BURIAL 6/6 1930
 20. UNDERTAKER N D Johnson ADDRESS Salem 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.

APR 10 1967