

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

Do not use this space.

19356

1. PLACE OF DEATH

County Jackson
Township Kaw
City Muskegette

Registration District No. 399
Primary Registration District No. 1502

File No. _____
Registered No. 2341 (Ward)

2. FULL NAME

(a) Residence. No. 2413 E. 68th Terrace 15 Ward.

Length of residence in city or town where death occurred Lifetime 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 m 4. COLOR OR RACE wh 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) June 16, 1915

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>14</u>	<u>11</u>	<u>16</u>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) mo.

10. NAME OF FATHER Orville L. Renuick

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

12. MAIDEN NAME OF MOTHER Floy D. Mitchell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Kans.

14. INFORMANT Orville L. Renuick (Address) 2413 E. 68th Terrace

15. FILED 6/30 19 30 M. M. Kerowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 2, 1930

17. I HEREBY CERTIFY, That I attended deceased from May 29, 1930, to June 2, 1930, that I last saw him alive on _____, 1930, and that death occurred, on the date stated above, at 7:42 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Sepsis
following
infectious mononucleosis
with the fact (duration) yrs. mos. ds. 6

CONTRIBUTORY (SECONDARY) 176 (duration) yrs. mos. ds. 36

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) John D. Spivey M. D. 1930 (Address) 336

*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 Forest Hill DATE OF BURIAL June 5, 1930

20. UNDERTAKER S. H. Newcomer ADDRESS 10th & Olive

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.

506 (7/10/10) (10/10)
506 7050
1:30 - 5:30