

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

Do not use this space.

19362

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township New Primary Registration District No. 100
 City Wegmo (No. Wegmo Hoop # 2) St. _____ Ward)

File No. _____
 Registered No. 2249

2. FULL NAME

(a) Residence. No. 1301 Woodlark Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 9 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 Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 26, 1904

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
25 9 6

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Jefferson City
 (STATE OR COUNTRY) Mo

10. NAME OF FATHER Geo. Davis

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

12. MAIDEN NAME OF MOTHER Martha White

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

14. INFORMANT File Clerk
 (Address) City Hoop # 2

15. FILED 6/4 30 1930 M. M. Crowe REGISTRAR
Ass

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-2-30 1930

17. I HEREBY CERTIFY, That I attended deceased from 5-29-30 to 6-2-30
 that I last saw him alive on 6-2-30, 1930, and that death occurred, on the date stated above, at 300 pm m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septicemia
194/13
35 (duration) yrs. mos. 4 ds.

CONTRIBUTORY (SECONDARY) Injury (at home)
(unintended) Injury suffered
to have occurred in lifting a
barber chair (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED at home
 IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) H. M. Smith M.D.
6/3, 1930 (Address) City Hoop # 2

*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.

20. PLACE OF BURIAL, CREMATION, OR REMOVAL Jefferson City, Mo DATE OF BURIAL 6/4 1930

21. UNDERTAKER Hatkins Bros. 1729 Lydia
 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.

