

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

Do not use this space.

19726-a

1. PLACE OF DEATH

County Jackson
 Township Blue
 City Leeds

Registration District No. 399
 Primary Registration District No. 1002
 (No. Leeds Hospital)

File No. _____
 Registered No. 3441
 St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 2403 Flow 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 <u>Male</u>	4. COLOR OR RACE <u>Negro</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>3-10-74</u>				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
<u>56</u>		<u>3</u>	<u>13</u>	
8. OCCUPATION OF DECEASED				
(a) Trade, profession, or particular kind of work. <u>Butcher</u>				
(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) Mississippi

PARENTS	10. NAME OF FATHER <u>Huggins Shade</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Virginia</u>
	12. MAIDEN NAME OF MOTHER <u>unknown</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>unknown</u>

14. INFORMANT K.C. T.B. Hospital (Address) Leeds Mo

15. FILED 8/19/30 M. M. Crowe REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-23-1930

17. I HEREBY CERTIFY, That I attended deceased from June 20, 1930, to June 23, 1930 that I last saw him alive on June 23, 1930, and that death occurred, on the date stated above, at 11 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Primary Tuberculosis
23A (duration) 0 yrs. 4 mos. 0 ds.

CONTRIBUTORY (SECONDARY) Went (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH. unknown

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical Lab.
 (Signed) [Signature], M. D.
July 17, 1930 (Address) 1830 West St

19. PLACE OF BURIAL, CREMATION, OR REMOVAL K.C. Western Dental School DATE OF BURIAL 7-1 1930

20. UNDERTAKER Mo State Anatomical Board ADDRESS Forrest St

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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