

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

Do not use this space.

19732

1. PLACE OF DEATH

County Jackson
 Township Argyle
 City Little Blue

Registration District No. Hoo
 Primary Registration District No. 1000010

File No. _____
 Registered No. 86
 _____ St. _____ Ward)

2. FULL NAME

(a) Residence No. 913 Independence St., _____ Ward. _____
 (Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. _____ ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm. C. Mason
widowed

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 18 - 1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
60 8/10 20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Common Laborer
 (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) Virginia

PARENTS

10. NAME OF FATHER Clayton Grant

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

12. MAIDEN NAME OF MOTHER Hannah Spotsdane

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

14.

INFORMANT Mary Campbell
 (Address) 2417 E. 23rd St. No. 110

15. June 12, 1930 M. S. James REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-8-30 19

17. I HEREBY CERTIFY That I attended deceased from 6-1-30 to 6-8-30, 1930
 that I last saw him alive on 6-8-30, 1930, and that death occurred, on the date stated above, at 6 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arterial deceleration
of aortic - mitral insufficiency

(duration) _____ yrs. _____ mos. 15 ds.

CONTRIBUTORY (SECONDARY)

(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Physician Exam.

(Signed) L. W. Bostan, M. D.

6-19-30 (Address) 2128 - Vine

*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

DATE OF BURIAL

The Ridgeway Cemetery 6-14-30 19

20. UNDERTAKER

ADDRESS

Flynn & Greenstreet K.C. 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.

