

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

Do not use this space.  
 20439  
~~20537~~

**1. PLACE OF DEATH**

County St. Francois  
 Township St. Francois  
 City Farmington, Mo. (No. .... St. .... Ward)

Registration District No. 773  
 Primary Registration District No. 6018A

File No. ....  
 Registered No. 97

**2. FULL NAME** William Bloss

(a) Residence. No. St. Louis, Mo. St. .... Ward. ....  
 (Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
77 ? ?

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) Unknown  
 (STATE OR COUNTRY) Unknown

10. NAME OF FATHER Unknown  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown  
 (STATE OR COUNTRY) .....  
 12. MAIDEN NAME OF MOTHER Unknown  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown  
 (STATE OR COUNTRY) .....

14. INFORMANT Hospital Records  
 (Address) Farmington, Mo.

15. FILED 6/24/30 T. J. Robinson  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 24, 1930

17. I HEREBY CERTIFY, That I attended deceased from May 24, 1930, to June 24, 1930 that I last saw him alive on June 23, 1930, and that death occurred, on the date stated above, at 2 h m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Prostate in involvement  
(Probably of a malignant nature) 5/6

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

**CONTRIBUTORY (SECONDARY)**

409

(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 clinical  
 (Signed) P. J. ..., M. D.

, 19 (Address) 409 # 4 Farmington, 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 Bellefontaine Cem DATE OF BURIAL 6/25/30

20. UNDERTAKER Elkander Bros ADDRESS 6150 Delmar

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.

THIS IS A PERMANENT RECORD

