

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

Do not use this space.

21129 ~~21129~~

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **1003 #2**

File No.....
Registered No. **5983**
St. **Ward**

2. FULL NAME

(a) Residence. No. **2127 Randolph St., 22** 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 <i>Male</i>	4. COLOR OR RACE <i>Col</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>wid</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Unknown</i>		
7. AGE <i>50</i>	YEARS	MONTHS
		DAYS
		If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <i>Car Washer</i> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN) *Miss*
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <i>Unknown</i>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Unknown</i>
	12. MAIDEN NAME OF MOTHER <i>Margaret Hobbit</i>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Miss</i>

14. INFORMANT *A. Gertrude Creath*
(Address) *City Hospital #2*

15. FILED *May 1930*
REGISTRAR

4 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *6-16 1930*
17. I HEREBY CERTIFY, That I attended deceased from *6-7 1930* to *6-16 1930*, that I last saw him alive on *6-16 1930*, and that death occurred, on the date stated above, at *6:15* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chol. hepatitis 137
131
135A
(duration) *1* yrs. *0* mos. *0* ds.
CONTRIBUTORY *Urinary Parasitosis*
(SECONDARY) *due to enlarged prostate*
(duration) *2* yrs. *0* mos. *0* ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH *Home*
1 *12/10/29* DIED AN OPERATION PRECEDE DEATH *eyes* DATE OF *6-16-30*
WAS THERE AN AUTOPTIC *Supra-pubic*
WHAT TEST CONFIRMED DIAGNOSIS? *Cystostomy*
(Signed) *D. Deather*, M. D.

6/17 1930 (Address) *City Hospital #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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Columbus Miss* DATE OF BURIAL *6-20-1930*

20. UNDERTAKER *W. S. Wade Undertaker* ADDRESS *4202*

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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