

AUG 20 1930

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

Do not use this space.

21958

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.

1. PLACE OF DEATH

County Buchanan
Township Dr. Joseph
City Dr. Joseph

Registration District No. 85
Primary Registration District No. 1001

File No. _____
Registered No. 783
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Dr. Joseph Mo. St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 1863

7. AGE YEARS 67 MONTHS Unknown DAYS Unknown IF LESS than 1 day, _____ hrs. _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer) 11
(c) Name of employer _____

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

Unknown

PARENTS

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

14. INFORMANT State Hospital Records
(Address) Dr. Joseph Mo.

15. FILED 9 1930 REGISTRAR John G. W.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 3 1930

17. I HEREBY CERTIFY, That I attended deceased from June 29 1930 to July 3 1930 that I last saw him alive on July 3 1930 and that death occurred, on the date stated above, at 11:25 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
827
97

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

CONTRIBUTORY (SECONDARY) Arteriosclerosis

(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

(Signed) B. E. Miller M. D.

July 3, 1930 (Address) Dr. Joseph 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

Triplett Mo.

DATE OF BURIAL

7-6-1930

20. UNDERTAKER

Ransing Funeral Service

ADDRESS

724 Olive St. Joseph Mo.

MAR 31 1950