

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

Do not use this space.

21960

1. PLACE OF DEATH

County Ruchanan

Registration District No. 85

Township St. Joseph Mo

Primary Registration District No. 1001

City St. Joseph Mo

State Mo No. State Hosp #2

File No. _____

Registered No. 785

2. FULL NAME

(a) Residence. No. St. Joseph Mo St. _____ Ward. _____

(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

M

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

unknown

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 02/10/1863

7. AGE

YEARS 66

MONTHS 8

DAYS 27

If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Coal Mining

(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) unknown

10. NAME OF FATHER unknown

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT State Hospital Records

(Address) St. Joseph Mo

15. FILED 8/1930 John S. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 7 1930

17. I HEREBY CERTIFY, That I attended deceased from July 5 1930 **to** July 7 1930 **that I last saw him alive on** July 7 1930 **and that death occurred, on the date stated above, at** 2:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
82A

CONTRIBUTORY (SECONDARY) Un Oxygen of Iron (duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED 76
IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH? _____ **DATE OF** _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) D. E. Miles M. D. July 7 1930 (Address) St. 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 City Cem. **DATE OF BURIAL** 7/9/30 19

20. UNDERTAKER C. W. [Signature] **ADDRESS** Ruchanan 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.

AUG 20 1930

