

JUL 20 1930

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

Do not use this space.

22003

1. PLACE OF DEATH

County Bushanan Registration District No. 85
Township _____ Primary Registration District No. 1001
City St. Joseph, (No. Missouri Methodist Hospital.) St. _____ Ward _____

File No. _____
Registered No. 832

2. FULL NAME Charles Marion White.

(a) Residence. No. 3112 No. 11 th St. St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

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 Mary White

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 8 - 1853

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
76 10 10

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Dekalb Co, (STATE OR COUNTRY) Missouri.

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Connie Nelson, (Address) 204 W. Valley St.

15. FILED John G. [Signature] REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 18 1930
17. I HEREBY CERTIFY, That I attended deceased from 7/18/30 to 7/19/30

that I last saw him alive on 7/18/30 at 5:10 a and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Anemia
137
132 B

CONTRIBUTORY (SECONDARY) Hyperthroid Prostate (duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

1855
AT PLACE OF BIRTH

DID AN OPERATOR PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Chas Greenberg, M. D.

7/19, 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 DATE OF BURIAL

Theotone Cem. July 21 1930

20. UNDERTAKER ADDRESS

Fred W. Clark 5225 N. H Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JUL 21 1930

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