

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

Do not use this space.

23046

1. PLACE OF DEATH

County Jackson

Registration District No. 399

Township W

Primary Registration District No. 1002

City Jenks (No. General Hospital 2)

St. _____ Ward _____

File No. _____

Registered No. 3141

2. FULL NAME

(a) Residence No. 717 E 17 St. 3 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 MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) (unk) 1869

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
61 (unk)

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Coal Dealer
(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) unk

10. NAME OF FATHER unk

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

12. MAIDEN NAME OF MOTHER unk

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

14. INFORMANT Clerk as Record (Address) General Hosp # 2

15. FILED 7/23/30 W M Crowe REGISTRAR Clerk

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 15, 1930

17. I HEREBY CERTIFY, That I attended deceased from July 14, 1930 to July 15, 1930 that I last saw him alive on 7-14-30 and that death occurred, on the date stated above, at 6:53 PM

THE CAUSE OF DEATH WAS AS FOLLOWS:
1) Hypostatic Pneumonia
2) White Endocarditis

CONTRIBUTORY (SECONDARY) Arteriosclerosis (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____ (duration) 5 yrs. _____ mos. _____ ds.

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) H. St. Smith, M. D.

7/21/30 (Address) Gen. Hosp # 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 Leeds mo DATE OF BURIAL 7-24-30

20. UNDERTAKER A K Moore ADDRESS 1820 E 18

