

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

Do not use this space.

25261

1. PLACE OF DEATH

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

Registration District No. 791
Primary Registration District No. 1003

File No.....
Registered No. 7488
St..... Ward.....

2. FULL NAME

(a) Residence. No. 339 1/2 Taylor St., 12 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 5 - 1858

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
78 3 20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home
(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) Kentucky

PARENTS

10. NAME OF FATHER Samuel W. Doursman

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

12. MAIDEN NAME OF MOTHER Bessie M. Doursman

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

14. INFORMANT Mrs. Virginia Doursman
(Address) 3319 1/2 Taylor

15. FILED III 26 1930 M. C. Stanley
REGISTRAR

4 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 25 19 30

I HEREBY CERTIFY: That I attended deceased from April 25 to July 24, 1930, to July 25, 1930 that I last saw him alive on July 24, 1930, and that death occurred, on the date stated above, at 12:20 am

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septicemia
agranulocytic Angina
1930
1930 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Fracture of Right Neck
falling to floor
(duration) yrs. mos. da.

17. WHERE WAS DISEASE CONTRACTED? St. John's Hospital
IF NOT IN PLACE OF DEATH, CITY, STATE AND COUNTY

18. IF AN OPERABLE NON-PRECEDED DEATH, NO. DATE OF NO.

19. WHAT WAS THE CONFIRMED DIAGNOSIS? Labs. Clinical & Pathology
(Signed) John McH. Deane, M. D.

7/25, 1930 (Address) 816 Metropolitan Bldg
*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

Paris, Dublin Va 7-28 19 30

20. UNDERTAKER ADDRESS

Arthur J. Donnelly 2039 North St

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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