

SEP 24 1930

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

Do not use this space.

26323

1. PLACE OF DEATH

County Dunklin
Township South
City Keokuk (No. _____)

Registration District No. 288
Primary Registration District No. 4172

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

2. FULL NAME

Tom Milburn Baby

(a) Residence No. _____ St. _____ 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. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 29 - 30

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

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Tom Milburn

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

12. MAIDEN NAME OF MOTHER Marie Shepard

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

14. INFORMANT Beryl Milburn
(Address) Keokuk Mo

15. FILED 9/230 Thelma Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/31 1931

17. I HEREBY CERTIFY, That I attended deceased from 8-21, 1931, to 8-31, 1931
that I last saw h. _____ alive on 8-31, 1931, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1510
Obstruction of lungs
(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTOR empysemal tuberculosis
(SECONDARY) to mother
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

4 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) W. R. Gosage, M. D.
, 19 _____ (Address) Keokuk 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 Marsh Cem DATE OF BURIAL 9/1 1930

20. UNDERTAKER A. C. Lansdell ADDRESS Keokuk Mo

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Dunklin Registration District No. 288 File No. _____
 Township _____ Primary Registration District No. 4172 Registered No. _____
 City Kennett (No. _____) St. _____ Ward _____

2. FULL NAME Tom Melburn

(a) Residence. No. _____ St. _____ 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. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 29 - 30

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
2 8 2

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (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) _____

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) _____

14. INFORMANT (Address) _____

15. FILED 9/2 1930 Heuler Davis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/31 1930

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred on the date stated above, at _____.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Obstruction of lungs
Essential Eclampsia of
noted albuminuria
 (duration) yrs. mos. ds. 1

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

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

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) W. H. Gossage, M. D.
 _____, 19____ (Address) Kennett, 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

19

20. UNDERTAKER ADDRESS _____

N. B.—Every item of information should be carefully supplied. AGES should be stated EXACTLY. PHYSICIAN'S SIGNATURE should be written in plain ink, so that it may be properly classified. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain ink.

REGISTRARS \$1.00 N. B. GIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-26323