

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

Do not use this space.

26781

**1. PLACE OF DEATH**

County Jackson Registration District No. 399 File No. 3386  
 Township Kear Primary Registration District No. 399 Registered No. 3386  
 City Maunassett City (No. Prepared Park, West at 2 Ward)

**2. FULL NAME**

(a) Residence. No. 3033 Grand Ave. St. 3 Ward. (If nonresident, give city or town and State)  
 (Usual place of abode)  
 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 Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 30 1855

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
75 4 13

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work. Ans Buah  
 (b) General nature of industry, business, or establishment in which employed (or employer). Pruning Co  
 (c) Name of employer

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

10. NAME OF FATHER Thos Hand

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT (Address) Sarah M Hand  
3033 Grand

15. FILED 8/16/30 M. M. Crowe  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 13 1930

17. I HEREBY CERTIFY That I attended deceased from July 24 1930 to Aug 13 1930 that I last saw h. alive on July 30 1930 and that death occurred, on the date stated above, at 4:40 m.

**THE CAUSE OF DEATH WAS AS FOLLOWS:**

Uremia  
 (duration) yrs. mos. ds. 2.6  
 CONTRIBUTORY (SECONDARY) Prostatic Hypertrophy  
Urinary obstruction  
 (duration) yrs. mos. ds. 3

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH DID AN OPERATION PRECEDE DEATH? DATE OF 7. 26-30

19. WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) J. H. Sheldon M. D.

8-14-30 (Address) Box Course 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  
St. Maria's Aug 16 1930

20. UNDERTAKER ADDRESS  
Mrs. C. L. Forester K. C. 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.

Comerce Vi- 4175  
1915 Victor Li- 2438