

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

Do not use this space.

26782

1. PLACE OF DEATH

County Jackson
Township Frank
City Osborne (No. 207 W 7th)

Registration District No. 399
Primary Registration District No. 1002

File No. 3387
Registered No. _____
St. _____ Ward)

2. FULL NAME

(a) Residence. No. 207 W. 7th St. St. 1 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 ♀ 4. COLOR OR RACE col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1870

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
60

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) Missouri

PARENTS

10. NAME OF FATHER unknown

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT Mabel Hudson

(Address) 207 W. 7th St.

15. FILED 8/16 1930 M. M. Crowe REGISTRAR
asst.

20 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-13-30

17. Dr. P. H. Crowe
I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____,

that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic hyperacidity
13 1/2 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chronic interstitial nephritis
9 1/2 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED 207 W
IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? autopsy
8/12 (Signed) P. H. Crowe M. D.
308 (Address) Osborne

*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 Hopwood DATE OF BURIAL Aug 16 1930

20. UNDERTAKER Matthews Bros ADDRESS 1729 Hyde

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.

