

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

Do not use this space.

30119

1. PLACE OF DEATH

County Jackson

Registration District No. 2997

Township Lea

Primary Registration District No. 66E

City Kangasbites

(No. 1002) Virginia

File No. _____

Registered No. 3927

St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 1002 Virginia St. 2 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

M

4. COLOR OR RACE

Col.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

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

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

Aug 1874

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

56

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

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

(Address)

Nellie Matthews Jones
1002 Virginia

15. FILED

9/25 19 30 M. M. Grove

REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/23 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 23, 1930, 1930 that I last saw her alive on Sept 23, 1930 and that death occurred, on the date stated above, at 11:30 m.

177 THE CAUSE OF DEATH* WAS AS FOLLOWS:

131 Uremic poisoning
chronic nephritis
1565 (duration) yrs. mos. 6 ds.

CONTRIBUTORY (SECONDARY) poor nutrition
Food (Kind unknown) (duration) yrs. mos. 20 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) Howard M. Jones M.D.

9/24/30 (Address) 2225 Vine

*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

Highland Cem.

9/26 1930

20. UNDERTAKER

ADDRESS

Nathans & Brothel Co 179 Lydia

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.

