

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

Do not use this space.

30172

1. PLACE OF DEATH

County Jackson Registration District No. _____
 Township Frank Primary Registration District No. _____
 City Wassas City (No. 506 Lincolnwood) St. _____ Ward)

File No. _____
 Registered No. 3980
 St. _____ Ward)

2. FULL NAME

(a) Residence. No. 1506 Lincolnwood St. Ward. 13
 (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 W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 7 - 1862

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 6 22

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) La

10. NAME OF FATHER John Jurgley

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) no record

12. MAIDEN NAME OF MOTHER no record

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) no record

14. INFORMANT Maud Jurgley
 (Address) 1506 Lincolnwood

15. FILED 9/30, 19 30 M. M. Croome REGISTRAR
Am

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 29 1930

17. I HEREBY CERTIFY, That I attended deceased from Mr. J. 1930 to Oct 29 1930 that I last saw him alive on 9/29 at 9:45 a.m. and that death occurred, on the date stated above, at _____ m.

18. THE CAUSE OF DEATH WAS AS FOLLOWS:

Chronic Myocarditis
131
930

CONTRIBUTORY (SECONDARY)

Chronic interstitial nephritis (duration) 5 yrs 11 mos 24 ds.
2 - 6 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

19. WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? Laboratory
W. H. Keats M. D.

(Signed) 9/30, 19 30 (Address) 900 Keats 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 St Joseph Mo DATE OF BURIAL Oct - 1 - 1930

20. UNDERTAKER Mrs. C. L. Foster ADDRESS R. 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.

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