

OCT 30 1930

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

Do not use this space.

30567

1. PLACE OF DEATH

County *Monroe*
Township *Jackson*
City *Monroe* (No. _____)

Registration District No. *582*
Primary Registration District No. *5779*

File No. _____
Registered No. *39*
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. *Monroe Co. Infirmary* Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred *19* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Single*

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept. 21 1930*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *None*

17. I HEREBY CERTIFY, That I attended deceased from *Jan 2 1930* to *Sept 21 1930* that I last saw him alive on *9-21 1930* and that death occurred, on the date stated above, at *11:30 P. M.*

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. *69*

Cerebral Hemorrhage
8-10 (duration) *1* yrs. mos. ds.

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work *None* (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

CONTRIBUTORY (SECONDARY) *astro 5 stems* (duration) *5* yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH *None*

10. NAME OF FATHER *N.K.*

19. DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____ WAS THERE AN AUTOPSY? *no*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *N.K.*

WHAT TEST CONFIRMED DIAGNOSIS? *none* (Signed) *Geo. M. Pappas, M. D.*

12. MAIDEN NAME OF MOTHER *N.K.*

9/22, 1930. (Address) *Paris, Mo.*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *N.K.*

*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.

14. INFORMANT *Infirmary Records* (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *County Farm* DATE OF BURIAL *9/22 1930*

15. FILED *9/22 30* *H. C. Payne* REGISTRAR

20. UNDERTAKER *None* ADDRESS _____

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.

