

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

Do not use this space.

30618

1. PLACE OF DEATH

County *New Madrid*

Registration District No. *605*

Township *Comau*

Primary Registration District No. *4359*

City *Parma*

(No. _____)

File No. _____

Registered No. _____

St. _____

Ward _____

2. FULL NAME *Thomas Henry Miskell*

(a) Residence. No. _____

St. _____

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

Male

4. COLOR OR RACE

White

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

Married

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

Elizabeth Miskell

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

1862-9-5

7. AGE

YEARS
68

MONTHS

DAYS
0 18

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

Laborer (Common)

(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)

Ind

10. NAME OF FATHER

James Miskell

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

USA

12. MAIDEN NAME OF MOTHER

Dicia Pearce

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

USA

14.

INFORMANT

Elizabeth Miskell

(Address)

Parma Mo

15.

FILED

9-24-30

Mrs. C. S. Blackman

R. Mrs. V. B. Stevenson

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Sept 23 1930

17.

I HEREBY CERTIFY, That I attended deceased from

Mar. 1, 19*30*, to *Sept. 23*, 19*30*

that I last saw him alive on *Sept 18*, 19*30*, and that death occurred, on the date stated above, at *10:00 A. M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cirrhosis of liver
myocarditis
interstitial nephritis
17419 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

17419 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF _____

20. WAS THERE AN AUTOPSY? *No*

21. WHAT TEST CONFIRMED DIAGNOSIS *Clapal - hrins analy*

(Signed) *Geo W. Husted* M. D.

, 19 _____ (Address) *Parma Mo*

*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

Taylor Cemetery

Sept-24 1930

20. UNDERTAKER

J. C. Knight

ADDRESS

Parma 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.

OCT 31 1930

RECORD

