

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

Do not use this space.

30930
151

File No. _____
Registered No. _____
St. _____ Ward _____

OCT 31 1930

1. PLACE OF DEATH

County St. Francois
Township _____
City Star River (No. _____)

Registration District No. 224
Primary Registration District No. 20183
(No. 4465)

2. FULL NAME

(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) Infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 14, 1930

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 8 hrs. or 30 min.
X ✓ ✓ X

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Star River Mo
(STATE OR COUNTRY)

10. NAME OF FATHER Ernest Strong
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Cape Girardeau Mo
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Korner Turner
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Chicago Ill
(STATE OR COUNTRY)

14. INFORMANT Ernest Strong
(Address) Star River Mo

15. Sept 20 1930 W. J. Bryan
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 15 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 14, 1930, to Sept 15, 1930, that I last saw him alive on Sept 14, 1930, and that death occurred, on the date stated above, at 2:30 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Spina Bifida (meningocela)
1559113

(duration) _____ yrs. _____ mos. 13 ds.
CONTRIBUTORY (SECONDARY) none
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) E. Robinson M. D.
9/15 1930 (Address) Star River 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 advance mo DATE OF BURIAL Sept 15 1930

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.

