

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

32133

1. PLACE OF DEATH

County Peachman Registration District No. 85 File No. \_\_\_\_\_  
Township Washington Primary Registration District No. 1001 Registered No. 1109  
City St Joseph Mo (No. State Hospital #2) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

(a) Residence No. St Joseph Mo Ward \_\_\_\_\_ (If nonresident, give city or town and State)  
(Usual place of abode)  
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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown 1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
13 Unknown

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Painter  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Iceland  
(STATE OR COUNTRY) \_\_\_\_\_

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 State Hospital Records  
(Address) St Joseph Mo

15. FILED 9 19 30  
John L. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 6 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 26 19 29 to Oct 7 19 30  
that I last saw H.M. alive on Oct 7, 19 30, and that death occurred, on the date stated above, at 3:05 a m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Shock following Prostatectomy  
137

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) yrs. mos. ds.  
135

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
IF NOT AT PLACE OF DEATH \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_  
(Signed) B.C. Miles M. D.  
Oct 7 1930 (Address) St Joseph 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 State Hosp #2 Cemetery DATE OF BURIAL Oct 19 1930

20. UNDERTAKER E. G. Sidenfaden ADDRESS 602 So. 11

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.

