

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.

DEC 22 1930

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

Do not use this space.

33396<sup>a</sup>  
File No. \_\_\_\_\_  
Registered No. 91

1. PLACE OF DEATH  
County Lafayette Registration District No. 460  
Township Davis Primary Registration District No. 2624 a  
City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME ( Unknown Negro )  
(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 Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Unknown  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) About 30 years old  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
About 30 years old  
8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Unknown  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) Unknown  
(STATE OR COUNTRY)

PARENTS  
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 as above  
(Address) Higginsville, Mo.

15. FILED 10-22-30 Bessie @ Porter  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19  
17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Hemorrhage  
195  
10:30 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
CONTRIBUTORY (SECONDARY) gunshot wound  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

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

9 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no  
WHAT TEST CONFIRMED DIAGNOSIS?  
10/17/30 (Address) Edmund J. Isaac, M. D.  
Coroner

\*State the Disease CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MANNER AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SELF-KILLED, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Sharp DATE OF BURIAL 10/22/30 19\_\_\_\_

20. UNDERTAKER as above ADDRESS Higginsville,

