

DEC 20 1930

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

Do not use this space.

35400

1. PLACE OF DEATH

County Rochester

Registration District No. 85

File No. 1222

Township St Joseph Mo

Primary Registration District No. 1001

Registered No. 1222

City St Joseph Mo

State Hosp #2

St. _____ Ward _____

2. FULL NAME

(a) Residence, No. St Joseph Mo 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

M

4. COLOR OR RACE

W

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

Widower

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

Widower

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

Unknown

7. AGE

YEARS

MONTHS

DAYS

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

41

unknown

8. OCCUPATION OF DECEASED

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

Mechanic

(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)

Unknown

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

Address

State Hospital Records
St Joseph Mo

15. FILED

DEC 12 1930

John G. Vt

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 2 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 6 1929 to Nov 2 1930 that I last saw him alive on Nov 2 1930, and that death occurred, on the date stated above, at 11:05 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

General Paralysis of Insane

CONTRIBUTORY (SECONDARY) Unknown (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED 70

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) J. Miles M. D.

Nov 2, 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

Stairie Ridge Cem

DATE OF BURIAL

11/12 1930

20. UNDERTAKER

John Boughton St Joseph Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD
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.

