

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

Do not use this space.

1. PLACE OF DEATH

County Jackson
Township Kaw
City J. C. Mo. (No. 4500 Brighton)

Registration District No. 399
Primary Registration District No. 1002

File No. 36176
Registered No. 4782
St. _____ Ward _____

2. FULL NAME

Thomas Mattie Engle
(a) Residence. No. 4500 Brighton 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

Fe. White

4. COLOR OR RACE

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

Child

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

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

Nov-3-1930

7. AGE

YEARS

MONTHS

DAYS

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

- - 8

8. OCCUPATION OF DECEASED

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

Child

(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)

K. C. Mo.

10. NAME OF FATHER

Wm Engle

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

K. C. Mo.

12. MAIDEN NAME OF MOTHER

Francis Allen

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

14. INFORMANT

William Engle
(Address) 4500 Brighton Ave. J. C. Mo.

15. FILED

11/12/30 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Nov - 11 - 1930

17:

I HEREBY CERTIFY, That I attended deceased from

Nov 3, 1930, to Nov 11, 1930

that I last saw him alive on 11-11-1930, and that death occurred, on the date stated above, at 4:20 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage and Embolical Hemorrhage

1000 (duration) _____ yrs. _____ mos. 10 ds.
1210 CONTRIBUTORY degenerated Hemophiles (SECONDARY)

(duration) _____ yrs. _____ mos. 11 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AGTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) A. A. Joles, M. D.

Nov 12, 1930 (Address) 9321 E 30

*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

Forest Hill Nov 12 1930

20. UNDERTAKER

ADDRESS

Mrs. C. L. Forester J. C. 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.

21 5007
12:00 noon

[Handwritten signature]