

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

Do not use this space.

1. PLACE OF DEATH

County Jackson
Township Frank
City St. Charles (No. 100)

Registration District No. 399
Primary Registration District No. 100

File No. 36462
Registered No. 100
St. _____ Ward _____

2. FULL NAME

(a) Residence No. 2209 Highland 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 <u>Male</u>	4. COLOR OR RACE <u>negro</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Single</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Unknown</u>		
7. AGE <u>about 50</u>	YEARS	MONTHS
		DAYS
		IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>unknown</u> (c) Name of employer _____		

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

PARENTS	10. NAME OF FATHER <u>Unknown</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>
	12. MAIDEN NAME OF MOTHER <u>Unknown</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>

14. INFORMANT (Address) Marie Kelly 2509 Highland Ave

15. FILED 11/11/30 Wm. Lawrence REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-9-30

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1915 Fractured Skull
(Cause unknown)
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 2012
(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? Yes DATE OF _____

19. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? autopsy
(Signed) W. H. Hunt, M. D.
11/9/30 (Address) Repub. Co.

*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 Blue Ridge Lawn DATE OF BURIAL 11-11-30

20. UNDERTAKER W. W. Fiskline ADDRESS 1214 Vine

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.

