

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

Do not use this space.

38244

1. PLACE OF DEATH

County Sevier
Township Jefferson
City Jefferson No. _____

Registration District No. 810
Primary Registration District No. 6055

File No. _____
Registered No. 75
St. _____ Ward _____

2. FULL NAME John Troom

(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. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 29, 1848

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
82 0 29

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer). _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Amsterdam
(STATE OR COUNTRY) Holland

10. NAME OF FATHER not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Holland
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Holland
(STATE OR COUNTRY)

14. INFORMANT Mrs. E. Fighting
(Address) Memphis

15. FILED 12/12/30 E. E. Carver REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 28 1930

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to Nov 27, 1930
that I last saw him alive on Nov 27, 1930, and that death occurred, on the date stated above, at 12:50 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cardiac Asthma
and followed up with
pneumonia
12/19 (duration) yrs. 6 mos. da.

CONTRIBUTORY (SECONDARY) 5 valvular heart disease
12/13 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED 10/15
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

19. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) James Smithley, M. D.
12/10, 1930 (Address) Memphis

*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 Memphis cemetery DATE OF BURIAL 11/30/30

20. UNDERTAKER W. W. Wayne & Sons ADDRESS Memphis

N. B.—Every effort should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Scotland Registration District No. 810 File No.
 Township Jefferson Primary Registration District No. 6033- Registered No. 93
 City (No.) St. Ward

2. FULL NAME John Brown
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Wid

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work

(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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 28 1930

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cardiac Asthma and followed up with pneumonia Broncho
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) NO
 (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) M. D.
 , 19 (Address)

*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.

14. INFORMANT (Address)

15. FILED 1/7 3 1931 C. E. Cannon REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
 ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. A large penalty is imposed for the omission of any item of information. Exact statement of cause of death is most important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES—UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

AN 325.5