

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

Do not use this space

Paul's Doubles
File No. **19129**
Registered No. **973**
St. _____ Ward _____

1. PLACE OF DEATH

County Greene Registration District No. 318
Township Springfield Registration District No. 2001
City Boonville (No. 1400)

2. FULL NAME

(a) Residence. No. 1400 Boonville 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 9 - 1895

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
35 7 19

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) Boonville, Mo.

10. NAME OF FATHER

Wm. Foreman

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Olds

12. MAIDEN NAME OF MOTHER

Christine Hughes

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Olds

14. INFORMANT

(Address) Wm. Foreman and Christine Hughes, 1450 Highland St., Boonville, Mo.

15. FILED

12-28-30 Jos. Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/28 1930

17. I HEREBY CERTIFY, That I attended deceased from 12/27/30 to 12/28/30, 1930, that I last saw him alive on 12/28/30, 1930, and that death occurred, on the date stated above, at 9:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Pancreatitis

59
12/28
1930
18. WHERE WAS DISEASE CONTRACTED (duration) _____ yrs. _____ mos. _____ ds.
Home

CONTRIBUTORY Severe acidosis (SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? Clinical & Pathological

(Signed) Wm. Foreman, M. D.

12-28-30 (Address) med art Olds

*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

Boonville, Mo. Dec 29 1930

20. UNDERTAKER ADDRESS

Wm. Foreman Boonville

WRITING, WITH UNCHANGING 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 full terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

ENTER TO

F. J. Houder

NO. 10
TAS

Mr. Lon Sharp,
Health Dept.,
City,

My dear Mr. Sharp:

Your office just called and said that the death certificate of Thos. H. Foreman had been returned to you with the query as to whether the deceased had diabetes. The body was autopsied with the following findings: Chronic inflammation to a marked degree throughout the pancreas, with small areas of acute inflammation with pus formation in the head of the pancreas; inflammation and adhesions surrounding the pancreas. There were no other findings of significance. The patient exhibited in life glycosuria and an increase in blood sugar.

Dr. Murray Stone performed the autopsy and he and I were in accord that the sugar metabolism disturbance was due to destruction of the pancreas and did not represent a true diabetes mellitus. Tissue examination of the pancreas which was made later bear out this opinion.

I would suggest that this letter be sent back with the certificate so that the central authorities can decide. I do not know what they would classify this case to be, although I consider the case to be primarily pancreatitis and the glycosuria purely secondary.

Respectfully,



FTH'D:S

1930

S-39129

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Greene Registration District No. 218 File No. _____
 Primary Registration District No. 2001 Registered No. 973
 (No. _____ St. _____ Ward _____)
U.S. NAME Joseph J. A. Foreman
 (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** A (write the word)
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 _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/28 19 30
17. I HEREBY CERTIFY That I attended deceased from _____, 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:
Chronic Pancreatitis
 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Severe Acidosis
 (duration) yrs. mos. ds.
18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) _____, M. D.
 _____, 19____ (Address)

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) _____
14. INFORMANT _____ (Address) _____
15. FILED _____ 19____ REGISTRAR _____

*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** _____ 19____
20. UNDERTAKER _____ **ADDRESS** _____

SUPPLEMENTARY

WRITE IN PLAIN INK---THIS IS A PERMANENT RECORD

information should be stated EXACTLY. PHYSICIANS should state item of info: plain term that it may be properly classified. Exact statement of OCCUPATION. For CERTIFICATES UNTIL THEY ARE COMPLETE AS PER LAW

FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PER LAW

REGISTRARS SHA

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