

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

Do not use this space.

39437

5100

1. PLACE OF DEATH

County Jackson
Township 1st
City Kennett, Mo (No. 1002)

Registration District No. 389
Primary Registration District No. 1002

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

2. FULL NAME

(a) Residence. No. 1509 E 17th St Ward. 4

(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>W</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Jan 19 - 1889</u>		
7. AGE	YEARS	MONTHS
<u>41</u>	<u>10</u>	<u>21</u>
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <u>Labors</u>		
(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) W. Va

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

14. INFORMANT Nancy Cole
(Address) 1509 E 17th St

15. FILED 12-13-30 Wm M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/10/30

17. I HEREBY CERTIFY, That I attended deceased from 11/1/30, 19____, to 12/10/30, that I last saw him alive on 12/10/30, 19____, and that death occurred, on the date stated above, at 1:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS
Hypostatic Pneumonia
"Broncho"
819

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

18. WHERE WAS DISEASE CONTRACTED W. Va
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS Dr. M. Miller M. D.
(Signed) 12-13-19 30 (Address) Gen. Hospt. # 2

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Legnau</u>	DATE OF BURIAL <u>Dec 13 1930</u>
20. UNDERTAKER <u>Wm M. Crowe</u>	ADDRESS <u>1729 Lyden</u>

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.

