

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

Do not use this space.

39512

**1. PLACE OF DEATH**

County Johnson Registration District No. 399 File No. \_\_\_\_\_  
 Township Law Primary Registration District No. 1 Registered No. 51185  
 City Independence (No. Blair Hospital #2) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAMES**

(a) Residence No. 1916 C. High St. 2 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** Col **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Single  
(write the word)

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

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** Don't know

**7. AGE** YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
49

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

**10. NAME OF FATHER** Don't know

**11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)** Don't know

**12. MAIDEN NAME OF MOTHER** Don't know

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)** Don't know

**14. INFORMANT (Address)** Keith Hulsley 194171 - Fallock

**15. FILED** 1/18, 1930 M. W. Crow REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**2** **16. DATE OF DEATH (MONTH, DAY AND YEAR)** 12-12-30  
**17.**

I HEREBY CERTIFY, That I attended deceased from 1-1-20, 1930, 19\_\_\_\_, and that I last saw him live on 12-12-30, 19\_\_\_\_, and that death occurred, on the date stated above, at 7:30 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Carcinoma of esophagus  
69B undetermined ds.

CONTRIBUTORY Toxemia (SECONDARY) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED** 4400  
 IF NOT AT PLACE OF DEATH: \_\_\_\_\_

**0** DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_

(Signed) D. M. Miller M. D.

13, 1930 (Address) Genl Hosp #2

\*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** Westlawn Cemetery **DATE OF BURIAL** 12-18-30

**20. UNDERTAKER** Nathan J. Miller ADDRESS 15-2071-5th

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.

