

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

Do not use this space.

39670

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Reo Primary Registration District No. _____
City Hannibal (No. General Hosp #2) St. _____ Ward _____

File No. _____
Registered No. 5215 Ward _____
St. _____

2. FULL NAME

(a) Residence No. 318 E 3rd 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>Mexican</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>unknown</u>		
7. AGE <u>about 45 years</u> <u>unknown</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>Labourer</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) Mexico

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 Records Clerk (Address) General Hosp #2

15. FILED 30 1930 M. M. Crowe REGISTRAR
user

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 27 1930
17. I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1930, to Dec. 27, 1930 that I last saw him alive on Dec. 27, 1930 and that death occurred, on the date stated above, at 6:00 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
23A
69B

CONTRIBUTORY (SECONDARY) Typhemia (duration) _____ yrs. _____ mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) R. M. Miller, M. D.

Dec. 27, 1930 (Address) Gen. Hosp. no 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 Reeds DATE OF BURIAL 1/31 1930

20. UNDERTAKER West Appleton Jones ADDRESS Reeds

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

K. 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.

