

**SUPREME COURT STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

268

85

1. PLACE OF BIRTH

County Richman
Township St Joseph Mo
City St Joseph Mo

Registration District No. 1001
Primary Registration District No. State Hospital

File No. _____
Registered No. 85
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Chillicothe Mo St. _____ Ward _____

(Usual place of abode)
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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 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) 1856 Unknown

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
75 Unknown

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Mo
(STATE OR COUNTRY) _____

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT State Hospital Records
(Address) Joseph Mo

15. John G. W.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 21 1931

17. I HEREBY CERTIFY, That I attended deceased from Jan 21 1931 until Jan 21 1931, and that I last saw him alive on Jan 21 1931, and that death occurred, on the date stated above, at 7:40 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Thrombosis
67
50 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) None Depression Psychosis
(duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) J. E. Miles M. D.

Jan 21 1931 (Address) St Joseph Mo
*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 Chillicothe Mo DATE OF BURIAL Jan 23 1930

20. UNDERTAKER Jas D Gordon ADDRESS Chillicothe Mo

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.

FEB 18 1931

JAN 21 1931

JAN 21 1931

