

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

Do not use this space.

1617

1. PLACE OF DEATH

County Jackson Registrar District No. _____
Township Draw Primary Registration District No. _____
City St. J. Mo (No. _____) State Mo Ward _____

File No. _____
Registered No. 450
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 2420 Tracy 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

2. SEX Male 4. COLOR OR RACE negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr. 3 1877

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
54

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Sanitor
(b) General nature of industry, business, or establishment in which employed (or employer). 226
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cris. Cty, Ala.

PARENTS
10. NAME OF FATHER E. Spear
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) W. Tenn 31
12. MAIDEN NAME OF MOTHER Flora Bear
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) D. Tenn

14. INFORMANT Conie Bryant
(Address) 2420 Tracy

15. FILED 1/30 1931 H. M. Ferrow REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/26/31

17. I HEREBY CERTIFY, That I attended deceased from 1/6, 1931, 1/26/31 that I last saw him alive on 1/26/31, and that death occurred, on the date stated above, at 4:50 m.

108 THE CAUSE OF DEATH* WAS AS FOLLOWS:
1-30 Hypostatic Pneumonia
2-obur
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Glaumeruli
Nephritis (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH. 108

8 DID AN OPERATION PRECEDE DEATH? DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) D. M. Mells M. D.
1/27, 1931 (Address) Gen. 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 Blue Ridge Lawn DATE OF BURIAL 1/29 1931

20. UNDERTAKER Julius A. F. Fisher ADDRESS City

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.

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

