

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

Do not use this space.

11361

**1. PLACE OF DEATH**

County Jackson Registration District No. 329  
 Township Kaw Primary Registration District No. 3022 File No. 1070  
 City Kansas (No. General Hospital # 2) Registered No. 1070 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. 1613 Forest St., m. m. Carome  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>M</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED <u>S</u> (write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>None</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Mar. 7, 1899</u>		
7. AGE YEARS <u>32</u>	MONTHS <u>1</u>	DAYS <u>1</u> LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>937</u> (c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) <u>Fortsouth</u> (STATE OR COUNTRY) <u>Arkansas</u>		
PARENTS	10. NAME OF FATHER <u>Joseph Royster</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Unknown</u> (STATE OR COUNTRY)	
	12. MAIDEN NAME OF MOTHER <u>Unknown</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Unknown</u> (STATE OR COUNTRY)	
14. INFORMANT <u>Mildred Thomas</u> (Address) <u>1610 Holmes</u>		
15. FILED <u>4/9, 1931</u> m. m. Carome REGISTRAR <u>amr</u>		

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-7 1931

17. I HEREBY CERTIFY, That I attended deceased from 4-3, 1931, to 4-7, 1931 that I last saw him alive on 4-7-31, 1931, and that death occurred, on the date stated above, at 1:50 P. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Cerebral apoplexy

82A (duration) yrs. mos. 9 ds.

CONTRIBUTORY (SECONDARY) J. W. W. (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 (1)

WHAT TEST CONFIRMED DIAGNOSIS?  
4/9, 1931 (Signed) D. M. Miller, M. D.  
(Address) General Hospital

\*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  
Fort Smith, Ark DATE OF BURIAL Apr 9 1931

20. UNDERTAKER  
Adkins Bros. ADDRESS 2000 E. 12th

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.

