

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

Do not use this space.

16209

1. PLACE OF DEATH

County.....
Township.....
City..... *Solons*

Registration District No. **701**
Primary Registration District No. **1008**
(No. *St. Luke Hospital*)

File No.....
Registered No. **4688**
St. Ward)

2. FULL NAME

(a) Residence. No. *1900 Louisiana* St. *17* 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 *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) *Apr 6 - 1907*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
24 - 11

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *Printer - 55*
(b) General nature of industry, business, or establishment in which employed (or employer). *Not employed*
(c) Name of employer

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

Solons Mo. 1

PARENTS

10. NAME OF FATHER *unknown*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Mo. 31*

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT *Miss Julia Upshaw*
(Address) *1900 Louisiana St*

15. FILED *APR 10 1931* *W. C. Standley* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Apr 17* 19 *31*

17. I HEREBY CERTIFY, That I attended deceased from *Jan 19* 19 *31*, to *April 17* 19 *31*, that I last saw him alive on *April 17* 19 *31*, and that death occurred, on the date stated above, at *5:25 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Myocardial Heart Failure
Secondary to Mitral Stenosis*
(duration) *2* yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *92A*
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? DATE OF *Apr 6*

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? *Dead Heart*
(Signed) *Alphonse M. Upshaw* M. D.
, 19 (Address) *806 Mason Bldg.*

*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 *Wesleyan Cemetery* DATE OF BURIAL *Apr 20 1931*

20. UNDERTAKER *Petty Bros 3029 Lafayette St* ADDRESS

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.

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