

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

Do not use this space.
18075

1. PLACE OF DEATH

County Jackson
Township New
City Jackson City (No. 1419) Locust

Registration District No. 399
Primary Registration District No. 1002

File No. 2216
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 1419 Locust 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 male
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) not known

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) unknown

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
guess 75

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work laborer
(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) not known

10. NAME OF FATHER

not known

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) not known

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) not known

14.

INFORMANT Coylar's
(Address) 1800 Lywood

15.

FILED 5-16-31 mmc REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Wednes 5-13 1931

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____, and that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocardis
109.
930
97
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Arterio sclerosis
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy

(Signed) Haney M. Hall M. D.

1913, 1931 (Address) Deputy Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Forest Hill DATE OF BURIAL 5-16 1931

20. UNDERTAKER

Coylar Funeral Home ADDRESS 1800 Lywood

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.

1.