

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

27564

1. PLACE OF DEATH

County Pichouan Registration District No. 85
 Township St. Joseph Mo Primary Registration District No. 1001
 City St. Joseph Mo State Hospital #2.1

File No. _____
 Registered No. 871
 St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 5737 Mc Gee Kansas Ct. Mo Ward. Kansas City Mo
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. 29 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE A 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF 1

6. DATE OF BIRTH (MONTH, DAY AND YEAR) unknown about 1878

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
53 unknown unknown

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work None
 (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) America unknown

10. NAME OF FATHER John J. Dumb

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

12. MAIDEN NAME OF MOTHER Ellen A. Mary

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

14. INFORMANT (Address) State Hospital Record St. Joseph Mo.

15. FILED 8-20 1931 John B. Bender REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 19 1931

I HEREBY CERTIFY, That I attended deceased from July 20, 1931 to Aug 19, 1931 that I last saw him alive on Aug 19, 1931, and that death occurred, on the date stated above, 11:20 P.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Acute Intestinal Obstruction
"Valvulus"

CONTRIBUTORY (SECONDARY) Fracture of femur (duration) yrs. mos. ds. 4 B
Accidental on foot (duration) yrs. mos. ds. 7

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

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Place of symptoms
 (Signed) W. Miller M. D.
Aug 19, 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 Kansas City, Missouri DATE OF BURIAL Aug. 21, 1931

20. UNDERTAKER Walter Meischner ADDRESS 1302 Faraon St. St. Joseph, Mo.

N. B. ... erfully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE ... that it may be properly classified. Exact statement of OCCUPATION is very important.

AUG 21 1931

Property of

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 85 File No.....
 Township..... Primary Registration District No. 1001 Registered No. 871
 City St. Joseph (No.) St. Ward)

2. FULL NAME

(a) Residence. No. 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) A

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

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

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
 (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)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED 10-3 19 31 John R Bender REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 19 1931

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

acute intestinal obstruction
"Valvulus"
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? (SECONDARY) Structure? Semur
accidental fall
on floor in ward at hospital

IF NOT AT PLACE OF DEATH,

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? 1860

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed), M. D.

, 19 (Address)

*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

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH if known, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-27564