

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

Do not use this space.

**1. PLACE OF DEATH**

County Saline Registration District No. 796  
Township Marshall Primary Registration District No. 3038  
City Marshall (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. 30235  
Registered No. 136

**2. FULL NAME**

(a) Residence. No. Mo State School St. Mo Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred 17 yrs. 6 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Aug. 7, 1908</u>		
7. AGE	YEARS <u>23</u>	MONTHS <u>?</u>
	DAYS <u>?</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____		

9. BIRTHPLACE (CITY OR TOWN) Greenfield, Mo  
(STATE OR COUNTRY) Osage Co., Mo

10. NAME OF FATHER R. K.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) R. K.  
(STATE OR COUNTRY) \_\_\_\_\_

12. MAIDEN NAME OF MOTHER R. K.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) R. K.  
(STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT (Address) Hospital Record Marshall Mo

15. FILED 8-25, 1931 Mrs John H. McQuire REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 22, 1931

17. I HEREBY CERTIFY, That I attended deceased from March 5, 1928, to Aug. 22, 1931 that I last saw him alive on Aug. 20, 1931, and that death occurred, on the date stated above, at 10:00 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Pulmonary Tuberculosis

23A (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (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

WHAT TEST CONFIRMED DIAGNOSIS Clinical, X-Ray  
(Signed) H. H. Hopes, M. D.  
123 1931 (Address) Marshall 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 Mo. State School Cem DATE OF BURIAL Aug 24 1931

20. UNDERTAKER L. R. Vandiver ADDRESS Marshall Mo.

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.

SEP 28 1931

WHITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

