

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

Do not use this space.

37696

4562

1. PLACE OF DEATH

County Jackson
Township
City H. C. Mo. (No. Research Hoop)

Registration District No. 399
Primary Registration District No. 1 C 2

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

2. FULL NAME

(a) Residence, No. 3749 Wyoming 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 Fe 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWER, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. E. Conner

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 20-18 43

7. AGE YEARS 88 MONTHS 6 DAYS 23 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. none
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York

FATHER 13. NAME Edward Rickards

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England

MOTHER 15. MAIDEN NAME Celestia

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N. Y.

17. INFORMANT Myrtle E. Graham
(ADDRESS) 3751 Wyoming

18. BURIAL, CREMATION, OR REMOVAL PLACE Edinwood DATE 1-16 1931

19. UNDERTAKER W. L. Trustler
(ADDRESS) W. L. Trustler

20. FILED 11/14 1931 M. M. Crowe
Registral.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 13 1931

22. I HEREBY CERTIFY, That I attended deceased from Oct 21- 1931, to Nov 13- 1931

I last saw him alive on Oct 13 1931. Death is said to have occurred on the date stated above, at 7:20 P. M.

The principal cause of death and related causes of importance were as follows:

Lobar Pneumonia Hypostatic
Lobar
1860
194 B
Other contributory causes of importance: 108

Fracture Femur
Acc fall on floor at home

Name of operation _____ Date of _____
What first confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury 10-17 1931
Where did injury occur? in home
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury fall in home
Nature of injury fracture neck femur

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____
(Signed) N. A. Leonard M. D.
(Address) 1115 Grand St. 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.

WHITE PLAINLY, WITH OUTLINES

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