

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

Do not use this space.

9287

1. PLACE OF DEATH

67 County Mississippi
3 Township Franklin
4 City Charleston (No. _____)

Registration District No. 566
Primary Registration District No. 3030

File No. _____
Registered No. 18
St. _____ Ward) _____

2. FULL NAME

Frank Mix

(a) Residence. No. _____ St. _____ Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U.S., if of foreign birth? _____ yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 25th 1869

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
67 2 18

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer 297
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

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

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown 4
(STATE OR COUNTRY)

14. INFORMANT Lela Mix
(Address) Charleston Mo.

15. FILE NO. 13, 1932 278 Wagon

REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

11:25 AM

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-12 1932

17. I HEREBY CERTIFY, That I attended deceased from 7/31/31
1931, to 2-12, 1932

that I last saw h. l. r. alive on 2/12, 1932, and that death occurred, on the date stated above, at 11:25 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy
hypertension & nephritis
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) at least 7 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH (1)

0 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Blood picture & Urinalysis

(Signed) E. C. Clark M. D.

. 19 _____ (Address) Charleston 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 at home DATE OF BURIAL 3-12 1932

20. UNDERTAKER _____ 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.

APR 28 1932

Dr. Conway

