

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. 791
Primary Registration District No. 1003
St. Joseph Hosp # 2

File No. 10098
Registered No. 2108
St. Ward)

2. FULL NAME

(a) Residence No. 1010 N. 9th St., 25 Ward.

(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: M.
4. COLOR OR RACE: C
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word):

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): June 30 - 1930

7. AGE: YEARS 1, MONTHS 8, DAYS 2. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Chief
(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): St. Louis, Mo.

10. NAME OF FATHER: Louis Spinks

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ark.

12. MAIDEN NAME OF MOTHER: Eva Hatchman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ill.

14. INFORMANT: Eva Spinks (Address) 1010 N. 9th

15. FILED: Mar 19 1932 Registrar: W. C. Tarkenton

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): March 19 32

17. NO Physician in Attendance
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 5:15 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho Pneumonia (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: 17

DID AN OPERATION PRECEDE DEATH? DATE OF

3 WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS (Signed) J. W. Kerney M.D. (Address) Dep. Coroner

*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

Frater Dickson Mar 5 19 32

20. UNDERTAKER

ADDRESS 2620

J. W. Hughes Lawton

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.

Chronic

Acute Broncho
Pneumonia
follow measles
or whooping
cough 20%

**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.....
Township.....
City St Louis (No., St. Ward)

Registration District No. 791
Primary Registration District No. 1003

File No.
Registered No. 2108

2. FULL NAME

Jessie Lee Spinks
(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 M 4. COLOR OR RACE C 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S (write the word)

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.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED

JUN 7, 1932 Maxe Starck Registrar
5/13/32 (Address)

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 1, 1932

22. I HEREBY CERTIFY, That I attended deceased from to, 19.....

I last saw h..... alive on, 19..... Death is said to have occurred on the date stated above, at.....m.

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

Progressive pneumonia (Date of onset 4/1)

(Primary)

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? no Date of injury 19.....
Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury no injury
Nature of injury

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

If so, specify J. W. Keener M=D.
(Signed) Deputy Coroner

SUPPLEMENTARY

Every item of information should be carefully supplied. Every item of information should be stated EXACTLY. PHYSICIANS should state EXACTLY. DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRY SHALL NOT RECEIVE A FEE FOR CERTIFICATES U.S. THEY ARE COMPLETE AS PRESCRIBED BY LAW.