

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City.....

(No. *City Hospital*)

22244

2. FULL NAME

(a) Residence, No. *4352 Beck*
(Usual place of abode)

St. *15* Ward. *Flora Hill*

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *15* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

701

1003

13958

File No.....

Registered No.....

3258

St.....

Ward.....

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *widowed*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *June 6 - 1848*

7. AGE YEARS *93* MONTHS *9* Days *26* If LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *nil* 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Farmer* 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) *Xenia* (STATE OR COUNTRY) *Illinois*

FATHER 13. NAME *Unk*

14. BIRTHPLACE (CITY OR TOWN) *Marion County* (STATE OR COUNTRY) *Illinois*

MOTHER 15. MAIDEN NAME *Mary Unk*

16. BIRTHPLACE (CITY OR TOWN) *Kentucky* (STATE OR COUNTRY) *Hospital Information*

17. INFORMANT (ADDRESS) *City Hospital*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Flora Hill* DATE *4 - 4 32*

19. UNDERTAKER (ADDRESS) *B. Ranson, Und.*

20. FILED *APR - 1 1932* Registrar *Mar C. Parker*

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *April 2nd 1932*

22. I HEREBY CERTIFY, That I attended deceased from *Mar 29th 1932* to *April 2nd 1932*

I last saw him alive on *April 2nd 1932* Death is said

to have occurred on the date stated above, at *9:40 a.m.*

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

Senility Date of onset *?*
Chronic Myocarditis *?*

Other contributory causes of importance: *(D)*

Name of operation *93090* Date of.....
102/30

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?..... 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.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? *No*
If so, specify.....

(Signed) *Carl H. Hot*, M. D.
(Address) *City Hospital*

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

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.

W. S. Kins