

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

Do not use this space.

39742

1. PLACE OF DEATH

County *Jackson* Registration District No. _____
Township *Raw* Primary Registration District No. _____
City *R. P. Mo.* (No. *R. P. General Hosp.* - St. _____ Ward)

File No. _____
Registered No. *2552*
St. _____ Ward)

2. FULL NAME

(a) Residence, No. *111 - E - 14th*, St. *2* 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 *Fe* 4. COLOR OR RACE *wh* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Divorced*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *June 19 - 1898*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
34 0 6

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Housework*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *own home*

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation *23 35*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *31*

13. NAME *A. P. Johnson*

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

15. MAIDEN NAME *Margaret B. Stahl*

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

17. INFORMANT *Mrs. L. Van*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Forest Hill* DATE *June 28 - 1932*

19. UNDERTAKER *Mrs. C. L. Foster*

20. FILED *9/27* 19 *32* *M. M. Crowe* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *June - 25 - 1932*

22. I HEREBY CERTIFY That I attended deceased from *departed home*, 19 *32*

I last saw *deceased* alive on _____, 19 _____ Death is said

to have occurred on the date stated above, at *9:15 A.M.*

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

Suicide, Ficklorid Date of onset _____

as shown

163D / 163

Other contributory causes of importance: *(circled symbols)*

Name of operation _____ Date of _____

What test confirmed diagnosis? *autopsy* 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 *6/24 - 1932*

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? _____

If so, specify _____

(Signed) *Hubert H. Hays*, M. D.

Address *111 E 14th St*

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.

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

