

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.

*Megredy is named*

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

Do not use this space.

26309

1. PLACE OF DEATH

County *Jackson*  
Township *Jean*  
City *Kennett* (No. *Kennett General Hospital*)

Registration District No. *399*  
Primary Registration District No. *1002*

File No. *3217*  
Registered No. *3217*  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

(a) Residence, No. *2337 Brighton* St., *12* 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 *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *4-26-1889*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*43 3 25*

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Inspector at Board of 216*

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

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) *Missouri*

13. NAME *Wm. H. Megredy*

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

15. MAIDEN NAME *Sophronia Rulley*

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

17. INFORMANT *Recard Bleck* (ADDRESS) *Kennett Hospital*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Forest Hill* DATE *8-24* 1932

19. UNDERTAKER *Mrs. C. L. Fowler* (ADDRESS) *418 Brooklyn Ave*

20. FILED *Aug 22 1932* Registrar *M. J. Brown*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *8-21-1932*

22. I HEREBY CERTIFY, That I attended deceased from *8-19-1932* to *8-21-1932*

I last saw him alive on *8-21-1932* Death is said to have occurred on the date stated above, at *8:10 a.m.*

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

*Surgery of test*  
*Self-inflicted*  
*hemorrhage*  
*12:30*  
*17:30*  
Other contributory causes of importance:

Name of operation *Herniotomy* Date of *8-19-32*  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? *yes*

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? \_\_\_\_\_  
If so, specify \_\_\_\_\_

(Signed) *P. W. Williams*, M. D.  
(Address) *Sup't. K. P. Penn Hospital*

