

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

Do not use this space.

30462

1. PLACE OF DEATH *City Hospital # 1*
 County..... Registration District No.....
 Township..... Primary Registration District No.....
 City..... (No. *City Hospital # 1*)
 2. FULL NAME *Joseph Jeffries*
 (a) Residence, No. *1012 N 9th* 25 Ward.
 (Usual place of abode)
 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.

File No. *8121*
 Registered No. *1012 N 9th*
 St. _____ Ward)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>W</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Stella Jeffries</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>9-19-1883</i>		
7. AGE	YEARS <i>47</i>	MONTHS <i>5</i>
		DAYS <i>19</i>
		If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>21</i>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>17</i>	<i>Laborer</i>
	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) <i>Hermanville Miss</i>		
FATHER	13. NAME <i>Unknown Sheridan</i>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Miss.</i>	
MOTHER	15. MAIDEN NAME <i>Emily Beachum</i>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Miss</i>	
17. INFORMANT (ADDRESS) <i>Chas Parker 2629 B Franklin</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Father's Dickson</i> DATE <i>9-8-1937</i>		
19. UNDERTAKER (ADDRESS) <i>James Sheridan</i>		
20. FILED <i>SEP -7 1937</i> Registrar <i>W. C. Sisk</i>		

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *9-1-1937*

22. *The person named above died from*
 19 *at home*
 I last saw h. alive on 19..... Death is said to have occurred on the date stated above, *8:55 A. m.*
 The principal cause of death and related causes of importance were as follows:
Hypostatic pneumonia Date of onset
Fractured skull, edema of brain, removed when struck by auto in front of 1012 N 9th St about 8:50 PM 4/10/37 (Pedestrian)
 Other contributory causes of importance:
Accident

Name of operation..... Date of.....
 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 *4/10/37*
 Where did injury occur? *St. Louis Mo*
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
Public Place
 Manner of injury *Struck by auto*
 Nature of injury *Fractured skull*

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify
 (Signed) *J. W. ...*
 (Address) *St. Louis Mo*

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.

