

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

Do not use this space.

1378

1. PLACE OF DEATH
 48 County Jackson Registration District No. 309
 10 Township Leon Primary Registration District No. 1002
 9 City Kennett (No. Kennett Memorial Hospital St. _____ Ward _____)
 2. FULL NAME McElroy, Blaylock
 (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. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF No Record
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) No Record
 7. AGE YEARS 70 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. Laborer
 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) No record
 13. NAME No record
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No record
 15. MAIDEN NAME No record
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No record
 17. INFORMANT Robert Kalish
 (ADDRESS) K. B. General Hospital
 18. BURIAL, CREMATION, OR REMOVAL Green DATE 1-7-33
 PLACE _____
 19. UNDERTAKER Green & Johnson
 (ADDRESS) _____
 20. FILED 1-8-33 M. Carter
 _____ Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-7-1933
 22. I HEREBY CERTIFY, That I attended deceased from 1-6-1933, to 1-7-1933
 I last saw him alive on 1-7-1933 Death is said to have occurred on the date stated above, at 10:20 P.M.
 The principal cause of death and related causes of importance were as follows:
Bronchopneumonia
107A
107A
 Other contributory causes of importance: _____
 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 _____, 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) J. H. Green M. D.
 (Address) K. B. General Hospital

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.

