

**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. 11701
Township..... Primary Registration District No. 1000
City..... (No. ISOLATION HOSPITAL)

File No. 4093
Registered No. 1061
St. Ward

2. FULL NAME

(a) Residence, No. Hoker Innis 4206 Bethlen St. 15 Ward.

(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Nov 23 - 1916</u>		
7. AGE	YEARS <u>16</u>	MONTHS <u>8</u>
	DAYS <u>4</u>	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>School Boy</u>	
	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) <u>Holt, Ky.</u>		
MOTHER	13. NAME <u>Carl Innis</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Holt, Ky.</u>	
	15. MAIDEN NAME <u>Ma Hoker</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>	
17. INFORMANT (ADDRESS) <u>Carroll Innis</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>St. Matthew's Cem.</u> DATE <u>Jan 31 - 1933</u>		
19. UNDERTAKER (ADDRESS) <u>Isolation Hospital</u>		
20. FILED <u>Jan 31 1933</u> <u>Max C. Stanley</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 27 1933

22. I HEREBY CERTIFY, that I attended deceased from Jan 27 1933 to Jan 27 1933

I last saw him alive on Jan 27, 1933. Death is said to have occurred on the date stated above, at 11:55 pm.

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

Diphtheria, Nasal Fungal Date of onset 1-22
Bronchial 1-10
10 1-15
10 1-15

Other contributory causes of importance:
Sleeping posture 1-22
Cervical adenitis

Name of operation Tracheotomy, Guanoey 1-27

What test confirmed diagnosis? Clinical Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No Date of injury, 19.....
Where did injury occur?, 19.....
(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) John Schenbrenner, M. D.
(Address) ISOLATION 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.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

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