

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

Do not use this space.

7268

**1. PLACE OF DEATH**

County ..... Registration District No. **791**  
 Township ..... Primary Registration District No. **1093**  
 City ..... No. **ISOLATION HOSPITAL** ..... St. .... Ward)

**2. FULL NAME**

(a) Residence, No. **4134** ..... Ward. ....  
 (Usual place of abode)  
 Length of residence in city or town where death occurred **10** yrs. .... mos. .... ds. / How long in U. S., if of foreign birth? yrs. .... mos. .... ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <i>M</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>nk - know w/h</i>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>March 22 - 1865 -</i>		
7. AGE <i>66</i>	YEARS	MONTHS
		DAYS
8. Trade, profession, or particular kind of work done, as <i>carpenter</i> , sawyer, bookkeeper, etc.		11. Total time (years) spent in this occupation
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)		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Osage - Missouri</i>		
13. NAME <i>nk know w/h</i>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
15. MAIDEN NAME <i>nk know w/h</i>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
17. INFORMANT (ADDRESS) <i>ISOLATION HOSPITAL</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>Galveston Cemetery</i> DATE <i>Feb 4<sup>th</sup></i> 19 <i>33</i>		
19. UNDERTAKER (ADDRESS) <i>Wasson Hotel</i> <i>2331 So Broadway</i>		
20. FILED <i>FEB - 2 1933</i> Registrar.		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb 1*, 19*33*

22. I HEREBY CERTIFY, That I attended deceased from *Jan 29*, 19*33* to *Feb 1*, 19*33*  
 I last saw him alive on *Feb 1*, 19*33*. Death is said to have occurred on the date stated above, at *1 P.M.*  
 The principal cause of death and related causes of importance were as follows:  
*Diabetes Mellitus*  
 Other contributory causes of importance: *due to Ehr. Uremia, Nephritis, Bronchopneumonia, 1-30, suppurab. Nos. Traumatic 1-20*  
 Name of operation: *none* Date of .....  
 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? *no* (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 *no*  
 (Signed) *John Schenck* M. D.  
 (Address) *ISOLATION HOSPITAL*

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.

MAXIMUM RESERVED FOR BINDING

S. NO. 2

