

MAY 22 1933

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

Do not use this space.

12475

1. PLACE OF DEATH

11 County Buchanan Registration District No. 85
5 Township St. Joseph Primary Registration District No. 16.01
9 City St. Joseph (No. State Hospital #2) State. St. Ward Ward

2. FULL NAME

John Jeffords
(a) Residence, No. 2201 15th 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) Divorced

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 7 1868

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
64 9 13

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Barber

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) Buchanan Mo

13. NAME John Jeffords

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

15. MAIDEN NAME Sarah Smith

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Buchanan Mo

17. INFORMANT (ADDRESS) Records State Hosp

18. BURIAL, CREMATION, OR REMOVAL State Hospital #2
PLACE St. Joseph Mo. DATE Apr. 22 1933

19. UNDERTAKER (ADDRESS) H. C. Sidenfaden
1802 Union St St. Joseph Mo.

20. FILED 4-22-1933 John R. Bunker
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 20 1933

22. I HEREBY CERTIFY, That I attended deceased from 1/8 1933, to April 20 1933
I last saw him alive on April 20 1933 Death is said to have occurred on the date stated above, at 12:00 m.

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

Chronic Nephritis Date of onset 10/1/32
Bladder Stone (?)
Tubo Ovarian 1/8/32

Name of operation Bladder Stone Date of 1/8/32
What test confirmed diagnosis? Bladder Stone Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? None Date of injury None, 1933

Where did injury occur? None
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury None
Nature of injury None

24. Was disease or injury in any way related to occupation of deceased? Yes
If so, specify Chronic Nephritis

(Signed) Dr. Sexton Smith, M. D.
(Address) State Hospital #2
St. Joseph 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.

1-1-226

