

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.

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

Do not use this space.

16667  
 2164

**1. PLACE OF DEATH**

County Jackson Registration District No. \_\_\_\_\_  
 Township Ycan Primary Registration District No. \_\_\_\_\_  
 City Rauven City (No. Rauven City General Hospital) \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
 Registered No. \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. 2838 Woodland St. Ward. \_\_\_\_\_  
 (Usual place of abode) \_\_\_\_\_ (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-19-1858

7. AGE YEARS 74 MONTHS 9 DAYS -1 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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

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) Alcira

13. NAME A. J. Fenton

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

15. MAIDEN NAME Franca Benk

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Maryland

17. INFORMANT (ADDRESS) Richard Blesh  
R. B. General Hospital

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE 5/2 1933

19. UNDERTAKER (ADDRESS) W. J. Mayberry  
City

20. FILED 5-20 1933 M. M. Grove  
Asst. Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-20, 1933

22. I HEREBY CERTIFY, That I attended deceased from 5-22, 1933, to 5-20, 1933

I last saw him alive on 5-20, 1933 Death is said to have occurred on the date stated above, at 11:00 a.m.

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

Terminal Broncho-pneumonia

107A

Other contributory causes of importance: 107a

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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. J. J. J. M. D.

(Address) R. B. General Hospital

