

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

Do not use this space.

25490

1. PLACE OF DEATH

113

County North Registration District No. 903
Township Satchel Primary Registration District No. 16212
City (No. Waller Blake) St. _____ Ward _____

File No. _____
Registered No. 22
St. _____ Ward _____

2. FULL NAME

(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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Olevis Jayson
6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 20 1900
7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
32 0 9

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Jarman
(b) General nature of industry, business, or establishment in which employed (or employer). _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) North Co Mo
(STATE OR COUNTRY)

10. NAME OF FATHER Drew Blake
11. BIRTHPLACE OF FATHER (CITY OR TOWN) North Co Mo
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Nora Jolley
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) North Co Mo
(STATE OR COUNTRY)

14. INFORMANT Waller Blake
(Address) Frank City Mo

15. FILED 8/30 John A. Andrews
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 29 1933
17. I HEREBY CERTIFY, That I attended deceased from July 29 1933 to July 29 1933
that I last saw him alive on July 28 1933 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Peritonitis Acute
1200
1200
(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) Ulcers of Colon
& Intestines (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) John A. Andrews M. D.
(Address) Frank City

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Frank City Mo DATE OF BURIAL 7-30-33

20. UNDERTAKER Andrews ADDRESS Frank City

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.

SEP 26 1933

