

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

Do not use this space.

29052

OCT 20 1933

1. PLACE OF DEATH
 County Chariton Registration District No. 172
 Township Salt Creek Primary Registration District No. 5239
 City (No.) St. (Ward)
 2. FULL NAME James P. Hess
 (a) Residence, No. St. Ward. (If nonresident, give city or town and State)
 (Usual place of abode)
 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 Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 14-1843
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
89 11 5
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer
 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) Jefferson Co. Ohio
 13. NAME John P. Hess
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
 15. MAIDEN NAME Marguerite Crow
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Miss Cecil Adickes
 18. BURIAL, CREMATION, OR REMOVAL PLACE Mt. Pleasant DATE _____ 19
 19. UNDERTAKER (ADDRESS) S. A. Soper
 20. FILED 9/19 1933 Bob West Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 19th 1933
 22. I HEREBY CERTIFY, That I attended deceased from Jan 5th 1933, to Sept 5th 1933
 I last saw him alive on Sept 5th 1933 Death is said to have occurred on the date stated above, at 4:45 a.m.
 The principal cause of death and related causes of importance were as follows:
Arterio Sclerosis with myocardial infarctus Date of onset 2003
930 930 930 930 930
 Other contributory causes of importance: Senility
 Name of operation _____ Date of _____
 What test confirmed diagnosis? Clinical Was there an autopsy? NO
 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? NO
 If so, specify _____
 (Signed) U. G. Back, M. D.
 (Address) Robbville, 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.

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