

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

Do not use this space.

36815

1. PLACE OF DEATH

County Jackson
Township New
City N. C. 7th (No. 1304 E. 16th)

Registration District No. 3-5-2
Primary Registration District No. 4-1-3

File No. 4839
Registered No. 4839
St. _____ Ward)

2. FULL NAME

(a) Residence, No. 1304 E. 16th St. _____ Ward. _____

(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 Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) unknown

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Don't know

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Don't know

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. Don't know

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Don't know

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) Don't know

13. NAME Don't know

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

15. MAIDEN NAME Don't know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

17. INFORMANT None (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE Blue Ridge Cem. DATE 12/12/33

19. UNDERTAKER (ADDRESS) West Apolliton

20. FILED 12/11 1933 M. M. Person Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 30th 1933

22. I HEREBY CERTIFY That I attended deceased from _____, 19____

I last saw him alive on _____, 19____. Death is said

to have occurred on the date stated above at _____ m.

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

Chronic nephritis Date of onset _____
Chronic hypochloria

Other contributory causes of importance: 131
930

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 related to occupation of deceased? _____

If so, specify _____

(Signed) [Signature] (Address) [Address]

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.

JAN 28 1934

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M. D.

