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

MAR 24 1934

Do not use this space.

474603

File No. 33

Registered No.

1. PLACE OF DEATH

County Greene — Registration District No. 318

Township Campbell — Primary Registration District No. 5440

City Springfield (No. U. S. Gov. Medical Center Hospital St. Ward)

2. FULL NAME James Pinkney

(a) Residence, No. Washington, D. C. St., Ward. Washington, D. C.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: Negro

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 15, 1893

7. AGE: YEARS 40 — MONTHS 8 — DAYS 4 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

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

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) unknown

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Washington, D. C.

FATHER

13. NAME William Henry Pinkney

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Maryland, U. S. A.

MOTHER

15. MAIDEN NAME Mary Tasker

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) U. S. A.

17. INFORMANT (ADDRESS) Deceased

18. BURIAL, CREMATION, OR REMOVAL
PLACE Removal DATE Feb. 20, 1934

19. UNDERTAKER (ADDRESS) Herman H. Lohmeyer Funeral Home, 458 E. Walnut St., Springfield, Mo.

20. FILED Feb. 20, 1934 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 19, 1934

22. I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1933, to Feb. 19, 1934

I last saw him alive on Feb. 19, 1934. Death is said to have occurred on the date stated above, at 2:30 P.m.

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

Tuberculosis Chronic Pulmonary — Date of onset

95 B

110 B

Other contributory causes of importance: Spontaneous Pneumothorax

Name of operation ..... Date of .....

What test confirmed diagnosis? Autopsy Was there an autopsy? yes

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) [signature], M. D.

(Address) Medical Center Springfield Md.