

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

Do not use this space.

APR 25 1934

1. PLACE OF DEATH

County Jackson Registration District No. 300
 Township W.C. Mo. Primary Registration District No. General Hospital #2
 City W.C. Mo. (No. 300 St. 3rd Ward)

File No. 5261

Registered No. 300

2. FULL NAME

(a) Residence, No. 1113 E. 17th 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 Male 4. COLOR OR RACE Colored 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) 3-2-1882

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
51 11 19

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

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) W.C. Mo.

13. NAME Unknown

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

15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Record Clerk
Genl Hosp #2

18. BURIAL, CREMATION, OR REMOVAL PLACE Leeds DATE 3-6 1934

19. UNDERTAKER (ADDRESS) H. B. Moore

20. FILED 3-2 1934 M. M. Crowe
Asst Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-21 1934

22. I HEREBY CERTIFY, That I attended deceased from 2-16 1934 to 2-21 1934

I last saw him alive on 2-21 1934. 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: (Date of _____)

Lobar Pneumonia
(right upper middle and lower lobes)

Other contributory causes of importance:

Toxemia

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ 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) G. O. Jones M. D.

(Address) General Hosp #2

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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