

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

Do not use this space.

9384

1. PLACE OF DEATH

Country Japan Registration District No. 411 File No. _____
 Township Galena Primary Registration District No. 2002 Registered No. _____
 City Galena (No. 703) Boardman 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) _____
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-26-34
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, ____ hrs. or ____ min. 3

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
 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) Galena Mo.

MOTHER 13. NAME Am. J. West

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Springfield Mo.

15. MAIDEN NAME Florence Davis

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wagoner Mo.

17. INFORMANT (ADDRESS) Am. J. West Galena Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Forest Hill DATES 3-27-34

19. UNDERTAKER (ADDRESS) Ed. D. Jones Galena Mo.

20. FILED 3-27-34 Ed. D. Jones Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-26-1934

22. I HEREBY CERTIFY, That I attended deceased from 3-26-1934 to 3-26-1934
 I last saw him alive on 3-26-1934 Death is said to have occurred on the date stated above, 3:00 m.

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

Blue baby
1570
 Other contributory causes of importance: One of triplets

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 in any way related to occupation of deceased? _____

If so, specify _____ (Signed) Ed. D. Jones

(Address) Galena Mo.

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.

