

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

Do not use this space.

MAY 25 1934

12819

**1. PLACE OF DEATH**

County Jackson Registration District No. 303  
 Township Shaw Primary Registration District No. 303  
 City Leeds Station (No. Leeds Tubercular Hosp) Registered No. 303 Ward

**2. FULL NAME**

(a) Residence, No. 0232 Wanda St., ..... Ward. (If nonresident, give city or town and State)  
 (Usual place of abode)

Length of residence in city or town where death occurred 15 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) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept-29-1908

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
26 6 5

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housework  
 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) Ark

FATHER 13. NAME Carroll - Jerry

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

MOTHER 15. MAIDEN NAME Mercier?

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

17. INFORMANT (ADDRESS) H.C.O.B. - Hosp - Leeds - Hosp

18. BURIAL, CREMATION, OR REMOVAL PLACE Paris Texas DATE 4-6-34

19. UNDERTAKER (ADDRESS) Mrs. L. L. Forster  
Kie. Mo.

20. FILED Apr 6 1934 M. M. Crowe Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April - 4, 1934

22. I HEREBY CERTIFY, That I attended deceased from Jan - 24, 1934, to April 4, 1934.

I last saw her alive on April 3, 1934. Death is said to have occurred on the date stated above, at 2 45 a.m.

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

Pulmonary Tuberculosis  
2 45  
 Other contributory causes of importance:

Name of operation ..... Date of .....  
 What test confirmed diagnosis? Sp. test 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) Paul C. Platt, M. D.  
 (Address) 925 Argyle Bldg.

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.

