

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

Do not use this space.

1. PLACE OF DEATH

County Jackson
Township Franklin
City J. C. Mo. (No. General Hospital #2)

Registration District No. 399
Primary Registration District No. 1002

File No. 17013
Registered No. 2382
St. 3rd Ward

2. FULL NAME

(a) Residence, No. 1510 E. 18th 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 Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1881

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
Wtd 53

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Chambermaid
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Hotel
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) La.

FATHER 13. NAME Dan Brazier

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

MOTHER 15. MAIDEN NAME Kimberly

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

17. INFORMANT (ADDRESS) Record Clerk

18. BURIAL, CREMATION, OR DISPOSAL PLACE Blue Ridge DATE 5/31

19. UNDERTAKER (ADDRESS) Watkins Bros

20. FILED 5/31 1919 M. J. Miller Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-25, 1934

22. I HEREBY CERTIFY, That I attended deceased from 5-16, 1934, to 5-25, 1934.
I last saw him alive on 5-25, 1934. Death is said to have occurred on the date stated above, at 11:48 P.M.
The principal cause of death and related causes of importance were as follows:
Date of onset

Specific Heart Disease
Cortic Regurgitation
92
Other contributory causes of importance:
Malcompensation

Name of operation Clinical Date of
What test confirmed diagnosis? Clinical Was there an autopsy? No

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.

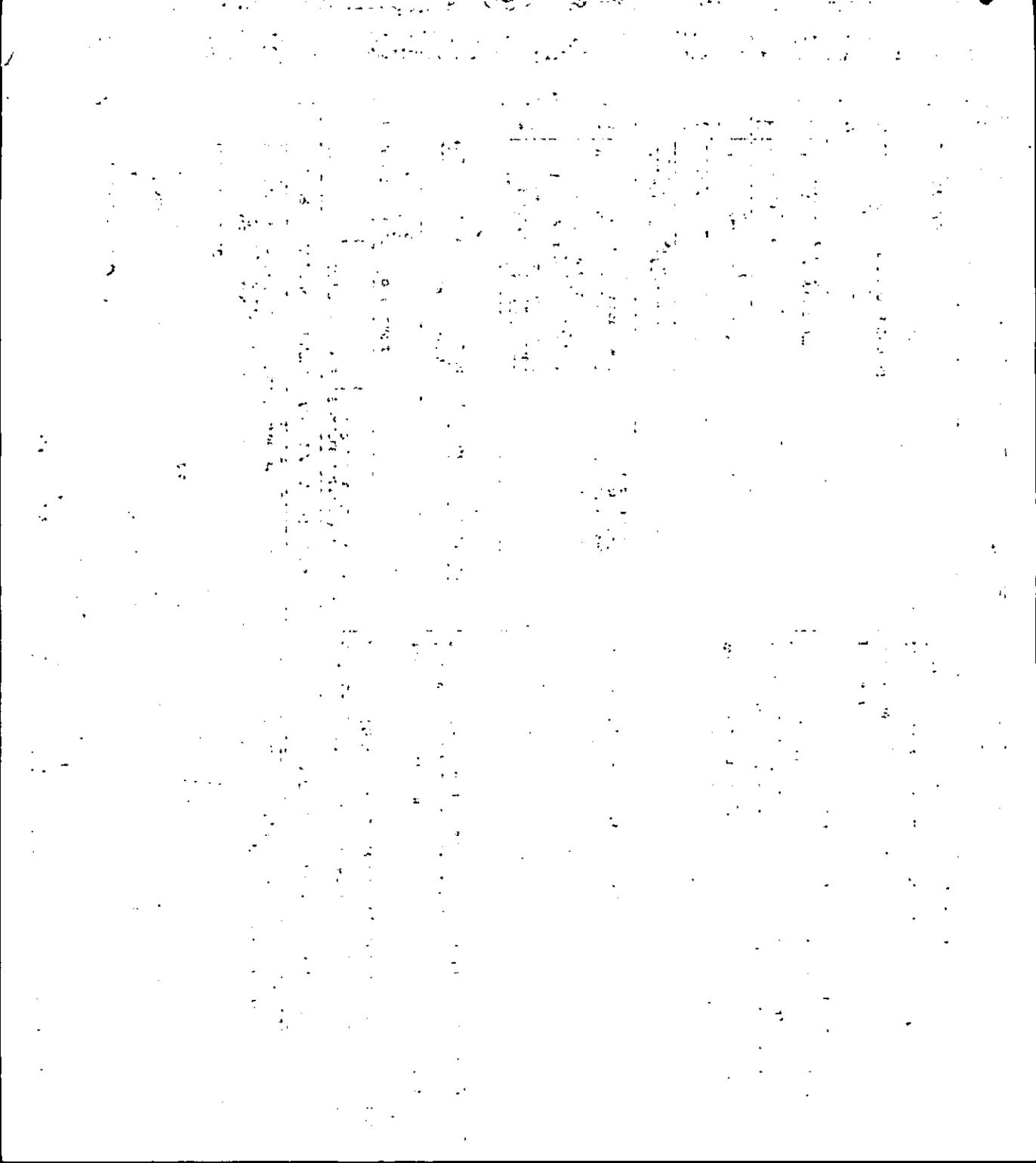
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) J. O. Jones M.D.
(Address) Clinical Dept. #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 OCCUPATIONS is important.

JUN 19 1934



Jackson

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Ide Grant
Who died at Gen Hosp on May - 25 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: _____ Years _____ Months _____ Days _____
Sex F Color or race: B Single, ~~married~~, widowed or ~~divorced~~: _____

Date of birth _____ Age: 41 Years 53 Months _____ Days _____

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____
Birthplace (State or country) Specific heart disease
Birthplace of father (State or country) _____
Birthplace of mother (State or country) _____

Principal cause of death: acute Regeneration Syphilitic
Other contributory causes of importance Decompensation

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
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 _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician _____

Address of physician _____
Signature of Registrar M. M. Kerowe Date filed 5/31/34

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 399 Very truly yours,
E. T. Mc Gaugh M.D.
Special Agent. E. C.

Primary Reg. Dist. No. 1002

RECEIVED BY THE DIRECTOR

GENERAL INVESTIGATIVE DIVISION

WASHINGTON, D. C.

U. S. DEPARTMENT OF JUSTICE

WASHINGTON, D. C.

APR 11 1934

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