

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

Do not use this space.

**1. PLACE OF DEATH**

County Jackson  
Township Ray  
City Ray Mo.

Registration District No. 399  
Primary Registration District No. 100  
(No. General Hospital #2)

File No. Y 24494  
Registered No. 5352  
St. 35th Ward

**2. FULL NAME**

(a) Residence, No. 1730 Michigan 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 Single  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-18-1880

7. AGE YEARS 54 MONTHS 3 DAYS 19 If LESS than 1 day, hrs. or min. 1  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Chauffeur

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) Tenn.

13. NAME May Darden

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

15. MAIDEN NAME Ben Darden

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

17. INFORMANT (ADDRESS) Recorl Clerk

18. BURIAL, CREMATION, OR REMOVAL PLACE Blair Ridge Lawn DATE July 13<sup>th</sup> 1934

19. UNDERTAKER (ADDRESS) A. J. Weber 2102

20. FILED July 13, 1934 M. M. Crowe Asst. Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-7 1934

22. I HEREBY CERTIFY, That I attended deceased from 6-28 1934, to 7-7 1934

I last saw him alive on 7-7 1934 Death is said to have occurred on the date stated above, at 8:05 P.M.

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

Hypostatic Pneumonia  
Terminal  
Hypertensive Heart Disease  
Date of onset

Other contributory causes of importance: Hypertensive Heart Disease

Name of operation Date of operation  
What test confirmed diagnosis Terminal 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

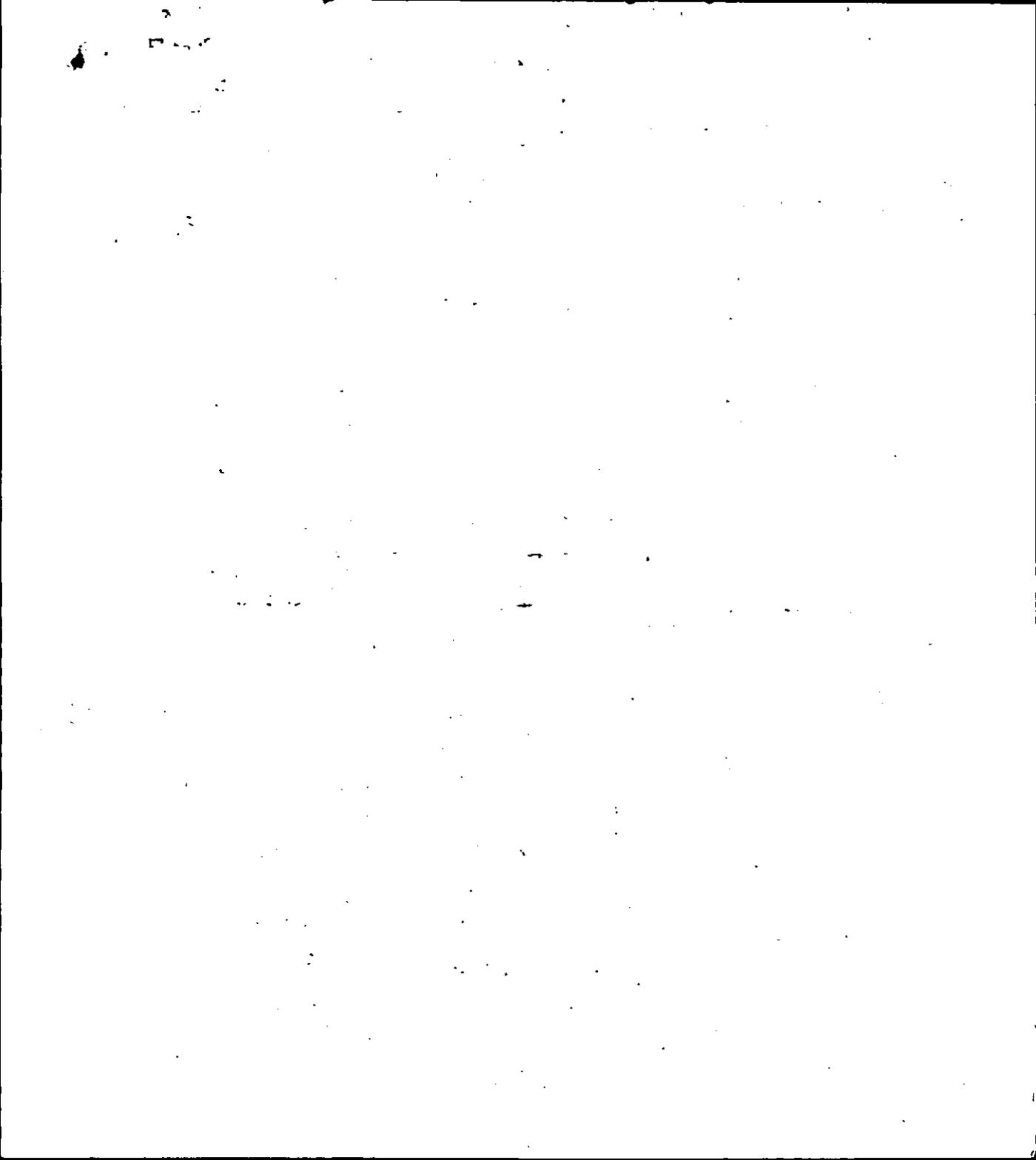
24. Was disease or injury in any way related to occupation of deceased? No  
If so, specify

(Signed) B. O. Fryer 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.

AUG 21 1934



*Kansas City*

*3092*

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: *Ben Darden*  
Who died at *General Hospital* on *7-7-1934*  
Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
Sex *M* Color or race *CoS* Single, married, widowed or divorced: \_\_\_\_\_

Date of birth \_\_\_\_\_ Age: Years *54* Months *3* Days *19*

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) \_\_\_\_\_

Birthplace of father (State or country) \_\_\_\_\_

Birthplace of mother (State or country) \_\_\_\_\_

Principal cause of death: *Hypostatic pneumonia (Terminal)*  
*Pulmonary pneumonia*

Other contributory causes of importance \_\_\_\_\_

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. Kerove* Date filed *7/13/34*

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*

Primary Reg. Dist. No. *1002*

Very truly yours,

*E. T. McLaugh, M.D.*  
Special Agent.

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