

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.

11-5-9

NOV 13 1934

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

Do not use this space.

**1. PLACE OF DEATH**

County Buchanan  
 Township St. Joseph  
 City St. Joseph

Registration District No. 85  
 Primary Registration District No. 1001

File No. 35267  
 Registered No. 1150  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. Cameron Mo  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Blanche Laughlin</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb. 3, 1902</u>		
7. AGE	YEARS <u>32</u>	MONTHS <u>8</u>
	DAYS <u>8</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>farmer</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>sign</u>	
	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) <u>De Kalb Co. Mo.</u>		
MOTHER	13. NAME <u>John Laughlin</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>De Kalb Co. Mo.</u>	
	15. MAIDEN NAME <u>Bertrude Lewis</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>De Kalb Co. Mo.</u>	
17. INFORMANT <u>Mrs. John Laughlin</u> (ADDRESS) <u>Cameron Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Deborn Mo</u> DATE <u>Oct. 13, 1934</u>		
19. UNDERTAKER (ADDRESS) <u>J. W. Poland</u> <u>Cameron Mo</u>		
20. FILED <u>10-12-34</u> <u>John R. Bender</u> Registrar.		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 11, 1934

22. I HEREBY CERTIFY, That I attended deceased from 10-8, 1934 to 10-11, 1934. I last saw him alive on 10-1, 1934. Death is said to have occurred on the date stated above, at 8:20 P. M.

The principal cause of death and related causes of importance were as follows:  
Pulmonary T. B.  
23A  
24A  
53

Other contributory causes of importance:  
Tubercular meningitis

Name of operation \_\_\_\_\_ Date of operation \_\_\_\_\_  
 What test confirmed diagnosis? Tubercy 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) A. G. Smith, M. D.  
 (Address) P. O. Box 1104  
St. Joseph Mo.

