

DEC 12 1934

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

Do not use this space.

38568

File No.
Registered No. 1243
St. Ward)

1. PLACE OF DEATH

County BuchananRegistration District No. 85

Township

Primary Registration District No. 1001

City

St. Joseph(No. St. Joseph Hospital)

2. FULL NAME

(a) Residence, No. 3004 Edmund 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 F 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) Jan. 10 - 1933

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 10 2

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) Saxton, Mo.13. NAME Felix Ratchiff14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Agency, Mo.15. MAIDEN NAME Lillian Spoon16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Saxton, Mo.17. INFORMANT (ADDRESS) Felix Ratchiff
3004 Edmund

18. BURIAL, CREMATION, OR REMOVAL

PLACE Buchanan DATE 11-14-34

19. UNDERTAKER (ADDRESS) H. W. Sullivan, Gayles, Mo.20. FILED NOV 1 1934 John R. Bender Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-12, 193422. I HEREBY CERTIFY, That I attended deceased from 11-1 1934, to 11-12, 1934

I last saw W alive on 11-11, 1934 Death is said

to have occurred on the date stated above, at 7 a.m.
The principal cause of death and related causes of importance were as follows:

Bronchopneumonia Date of onset 10-1-34

Other contributory causes of importance:

Name of operation none Date of 11-12-34
What test confirmed diagnosis? Microscopic Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 1934

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) Dr. Joseph T. Spore M. D.
(Address) St. Joseph, Mo.

