

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.

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

Do not use this space.

JAN 15 1935

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1. PLACE OF DEATH

County *Cape Girardeau*  
Township *Jackson*  
City *Jackson* (No. \_\_\_\_\_)

Registration District No. *124*  
Primary Registration District No. *4070*

File No. \_\_\_\_\_  
Registered No. *34*  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

(a) Residence, No. \_\_\_\_\_ 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 MEDICAL CERTIFICATE OF DEATH

3. SEX *male*  
4. COLOR OR RACE *negro*  
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *married*  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Nov. 1885*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *12-8-1934*

7. AGE YEARS *49* MONTHS *✓* DAYS *✓* IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

22. I HEREBY CERTIFY, That I attended deceased from *12-3-1934* to *12-8-1934*  
I last saw him alive on *12-8-1934* Death is said to have occurred on the date stated above, at *2 P. m.*  
The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Janitor*  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *10*  
10. Date deceased last worked at this occupation (month and year) *Nov. 1934*  
11. Total time (years) spent in this occupation *11*

*Pneumonia (Bronchial)* Date of onset \_\_\_\_\_  
*10/10/34*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *New Orleans, La.*

Other contributory causes of importance:  
*Bronchial Asthma*  
*Sarpygo-Spasm*

13. NAME *Emanuel Beal*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? *No*

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

15. MAIDEN NAME *Charity Beldridge*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Madison*

17. INFORMANT *Willie Beal* (ADDRESS) *Jackson, Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *City Cemetery* DATE *Dec 10 1934*

19. UNDERTAKER *Chapman Miller* (ADDRESS) *Jackson, Mo.*

20. FILED *12-10-34* 19 *34* *D. G. Suber* Registrar.

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) *Albert M. Ester*, M. D.  
(Address) *Jackson, Mo.*

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