

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

Do not use this space.

FEB 19 1935

1510

1. PLACE OF DEATH

County Jackson
Township St. Anthony
City St. Anthony (No. General Hosp. #2)

Registration District No. _____
Primary Registration District No. _____

File No. _____
Registered No. 326
St. 3rd Ward

2. FULL NAME

(a) Residence, No. 3205 E. 16th 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 Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-1-1879

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
55 5 14

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

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) Texas

13. NAME Tom Stone

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

15. MAIDEN NAME unknown

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

17. INFORMANT (ADDRESS) Record Clerk

18. BURIAL, CREMATION, OR REMOVAL

PLACE H. Worth Sep DATE Jan 24 1935

19. UNDERTAKER (ADDRESS) Nathan W. Halcher

20. FILED 1/24 1935 M M Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-15, 1935

22. I HEREBY CERTIFY, That I attended deceased from 1-7, 1935, to 1-15, 1935

I last saw him alive on 1-15, 1935 Death is said to have occurred on the date stated above, at 11:00 a.m.

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

Right
Lobary
Pneumonia

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? Culture 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) C. S. Jones 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.

