

JUN 1 8 1935

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

Do not use this space.

15644

1. PLACE OF DEATH

County *Dickinson*

Registration District No. **85**

Township

Primary Registration District No. **1001**

City *St. Joseph Mo* (No. *State Hospital # 2*)

File No. ....

Registered No. **533**

St. .... Ward)

2. FULL NAME

(a) Residence, No. *Green City St. Mo* 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

*M*

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)

*Year 1850*

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, ..... hrs. or ..... min.

*About 85*

*unknown*

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

*Farmer*

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)

*U.S.*

13. NAME

*Not known*

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

*Not known*

15. MAIDEN NAME

*Not known*

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

*Not known*

17. INFORMANT (ADDRESS)

*State Hospital Recorder, St. Joseph Mo*

18. BURIAL, CREMATION, OR REMOVAL

PLACE *Green City Mo* DATE *5-11-35*

19. UNDERTAKER (ADDRESS)

*Wesley E. Bent, Green City Mo*

20. FILED

*5-11-35 John R. Bender, Registrar.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 11, 1935*

22. I HEREBY CERTIFY, That I attended deceased from *May 7, 1935* to *May 11, 1935*

I last saw him alive on *May 11, 1935*. Death is said to have occurred on the date stated above, at *3:15* p.m.

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

*Chronic Myocarditis*

Date of onset

*930*

Other contributory causes of importance:

*Senility*

Name of operation *no* Date of

What test confirmed diagnosis? *chem* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? *no* 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 *None*

24. Was disease or injury in any way related to occupation of deceased? *no*

If so, specify

(Signed) *J. P. Smith*, M. D.

(Address) *State Hospital # 2*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

31  
31  
31

1001  
20