

SEP 18 1935

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

Do not use this space.

1. PLACE OF DEATH

County BuchananRegistration District No. 85

Township

City St. Joseph(No. State Hosp # 2) Registration District No. 1001File No. 25633Registered No. 849

St. _____ Ward _____

2. FULL NAME

(a) Residence, No. Jamesport Mo 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

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 1864

7. AGE

YEARS

MONTHS

DAYS

If less than 1 day, _____ hrs. or _____ min.

71__________

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)

unknown unknown

13. NAME

D. H. Bashford

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

Judsonia

15. MAIDEN NAME

Sarah Hood

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

Missouri

17. INFORMANT (ADDRESS)

Mrs J. E. Oxford Jamesport Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE

Funerary Home DATE 8-10-35

19. UNDERTAKER (ADDRESS)

Sam G. Jones 315 W 14th St Jamesport Mo

20. FILED

8-10-35 John M. Bender Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 9th 193522. I HEREBY CERTIFY, That I attended deceased from July 26, 1935, to Aug 9th, 1935I last saw him alive on Aug 9, 1935. Death is said to have occurred on the date stated above, at 6:00 a.m.

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

Chronic Myocarditis

Date of onset

Other contributory causes of importance

Name of operation _____ Date of _____

What test confirmed diagnosis? clinical 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) J. P. Bunch M. D.(Address) State Hosp # 2

