

SEP 25 1935

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

Do not use this space.

26429

1. PLACE OF DEATH

County Graham
Township John
City Leads Station (No. 1)
Van-City - Pike - Louise

Registration District No. 95
Primary Registration District No. 10

File No. 3176
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 4321 Genese St., Ward _____
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 20 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) Divorced.

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 24 - 1891

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
44 0 17

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

13. NAME Walls, Thomas

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn - ?

15. MAIDEN NAME Crow, Emma

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

17. INFORMANT (ADDRESS) J. C. J. B. Hosp - Leads Station

18. BURIAL, CREMATION, OR REMOVAL PLACE Forest Hill DATE Aug 12 - 35

19. UNDERTAKER (ADDRESS) Mrs. C. L. Foster 918 Broadway Ave

20. FILED 8-10 1935 M. M. Crow, Dist Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 10, 1935

22. I HEREBY CERTIFY, That I attended deceased from May 1, 1935, to Aug - 10, 1935. I last saw h. e. alive on August 9, 1935. Death is said to have occurred on the date stated above, at 1:50 P.M.

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

Pulmonary tuberculosis Date of onset Feb 1928
Tuberculous laryngitis
23

Other contributory causes of importance: none

Name of operation Pharyngotomy Date of 6-5-35
What test confirmed diagnosis? specimen 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. Hoffmann, M. D.
(Address) K. C. T. B. Hospital Leads, Mo.

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.

2
11
10