

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

Do not use this space.

30841

791

1003

File No. 7625

Registered No.

St. _____ Ward _____

1. PLACE OF DEATH

County.....

Registration District No. _____

Township.....

Primary Registration District No. _____

City.....

17 8989

2. FULL NAME

(a) Residence, No. _____
(Usual place of abode)

3314th

St. _____ Ward. 26

Length of residence in city or town where death occurred 30^{ths} yrs. mos. ds.

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Married

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

Living

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

Sept-27-1883

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

51

11

13

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

Nil

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

babaker

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)

Illinois

13. NAME

Frank Jennings

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

Illinois

15. MAIDEN NAME

Mathilda

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

Illinois

17. INFORMANT (ADDRESS)

Wm J. ...

18. BURIAL, CREMATION, OR REMOVAL

PLACE

DATE

Grant City Ill Sept 10 1935

19. UNDERTAKER (ADDRESS)

Jos ...

20. FILED

SEP 11 1935

19. J. H. Bredeck Registrar.

MEDICAL CERTIFICATE OF DEATH

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

Sept 10, 1935

22. I HEREBY CERTIFY, That I attended deceased from

9¹⁵ to Sept 10, 1935

last saw him alive on Sept 10, 1935. Death is said

to have occurred on the date stated above, at 9¹⁵ pm.

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

Bronchogenic carcinoma
- metastases to Brain

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____

If so, specify _____

(Signed) Za Mythen, M. D.

(Address) City, 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.

WHITE PAPER, WITH IMPROVING INK—THIS IS A PERMANENT RECORD

5-1-51
JAN 30 1951