

NOV 18 1935

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

Do not use this space.

31944

1. PLACE OF DEATH

County Buchanan

Registration District No. 85

Township

Primary Registration District No. 1001

City

St. Joseph Mo. State Hospital #1

File No. _____
Registered No. 1090
St. _____ Ward _____

2. FULL NAME

(a) Residence No. St. Joseph 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 1 yrs. 1 mos. 0 ds. How long in U. S., if of foreign birth? 1 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Caucas 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) Apr 1853

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min. abt 82

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

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) Buchanan Missouri

13. NAME Buchanan

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

15. MAIDEN NAME Buchanan

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

17. INFORMANT (ADDRESS) State Hospital, Buchanan, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Buchanan Cem DATE 10/24/35 1935

19. UNDERTAKER (ADDRESS) St. Joseph Mo. State Hospital

20. FILED 10-24-35 John R. Bender Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 23, 1935

22. I HEREBY CERTIFY, That I attended deceased from Apr 25, 1935 to Oct 23, 1935

I last saw him alive on Oct 23, 1935 Death is said to have occurred on the date stated above, at 8:15 a.m.

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

Cerebral Arteriosclerosis Date of onset unknown

Other contributory causes of importance: age

Name of operation _____ Date of _____
What test confirmed diagnosis? None Was there an autopsy? Yes

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? none (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 no

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____

(Signed) W. H. Miles, M. D.
(Address) State Hospital, Buchanan, 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.

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD.

30
31
32

