

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

Do not use this space.

36171

DEC 26 1935

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
 Township Ray Primary Registration District No. 1002  
 City J.R.C. Mo. (No. General Hosp. #2) St. St. Louis Ward 3rd

**2. FULL NAME**

(a) Residence, No. 608 Campbell St. St. Louis Ward 3rd  
 (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 Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-30-1902

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
33 4 16

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None  
 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) K.C. Mo.  
 (STATE OR COUNTRY)

FATHER MOTHER

13. NAME Mr. Robinson

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

15. MAIDEN NAME Malinda Slaughter

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

17. INFORMANT Record Clerk  
 (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE High Ridge Lawn DATE Nov. 20 1935

19. UNDERTAKER C. H. Coontee Son  
 (ADDRESS) 1606 E. 18th St

20. FILED Nov 19 1935 M. M. Cerone  
 Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-16 1935

22. I HEREBY CERTIFY, That I attended deceased from 11-5 1935 to 11-16 1935

I last saw him alive on 11-16 1935 Death is said

to have occurred on the date stated above, at 8:00 A.M.

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

Acute Military Tuberculosis  
Acute Tuberculous Meningitis  
 Other contributory causes of importance:  
Acute Tuberculous Laryngitis

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? Yes

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. O. Jones, M. D.  
 (Address) General Hosp. #2

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

