

FEB 25 1937

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

Do not use this space.

1379

1. PLACE OF DEATH

4th County Jackson
1st Township Jackson
1st City Jackson (No. 42)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 1190
St. _____ Ward _____

2. FULL NAME

Francis Eison
(a) Residence, No. 914 W. 17th St., _____ Ward. 1
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 -
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 _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 25 1873

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
63 5 13

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. 267
10. Date deceased last worked at this occupation (month and year) _____
11. Total time (years) spent in this occupation 31

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jackson

13. NAME Unknown

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

15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Second Clerk General Hospital

18. BURIAL, CREMATION, OR REMOVAL PLACE Plural Hills DATE 1-11-37

19. UNDERTAKER (ADDRESS) J. K. ...

20. FILED Jan 11, 1937 M. M. ...
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-8-37

22. I HEREBY CERTIFY, That I attended deceased from 1-2-37 to 1-8-37, 1937

I last saw he alive on 1-8-37, 1937 Death is said to have occurred on the date stated above, at 6:15 pm
The principal cause of death and related causes of importance were as follows:

Broncho pneumonia
myocardial scar
by atherosclerosis
Date of onset _____

Other contributory causes of importance: _____
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? _____
If so, specify _____
(Signed) P. J. De Maria M. D.
(Address) St. C. General Hospital

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

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.

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