

1939 FEB 21 1939

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

Do not use this space.

1. PLACE OF DEATH

County Lachman
Township St. Joseph, Mo.
City St. Joseph, Mo.

Registration District No. 85
Primary Registration District No. 1001

File No. 1612
Registered No. 10
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. Trade Bene Mo. St. Ward Little Blue, Mo.
(Usual place of abode)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OF RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 27-1887

7. AGE YEARS 51 MONTHS 11 DAYS 7 If LESS than 1 day, _____ hrs. or _____ min.

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

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) Mo

13. NAME William Sex

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

15. MAIDEN NAME Unknown

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

17. INFORMANT State Hospital No 2 (ADDRESS) St. Joseph, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Field Summit Cem. DATE 1-7-1939

19. UNDERTAKER Fields Funeral Home (ADDRESS) Field Summit, Mo.

20. FILED 1/6 1939 H. Needles Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 4 1938

22. I HEREBY CERTIFY, That I attended deceased from Jan 30 1938 to Jan 4 1939

I last saw him alive on Jan 4 1938 Death is said to have occurred on the date stated above, at 5:00 p.m.

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

Pulmonary Tuberculosis
Date of onset 7 2

Other contributory causes of importance:

Name of operation None Date of _____
What test confirmed diagnosis? X-ray, T. Test. 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) O. C. DeLong, M. D.
(Address) Mo State Hosp

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.

STATEMENT BY LICENSED EMBALMER

I, P. C. Fields, Licensed Embalmer No. 2957

hereby certify that the body recorded on the reverse side of this

Certificate was embalmed by me

or by _____, Registered Apprentice No. _____

(Signed) P. C. Fields
Licensed Embalmer No. 2957

NOTE: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
(Failure to comply with the above regulation constitutes grounds for revocation of license.)