

RECD MAR 9 1939

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

5356
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson
(b) Township Jean
(c) City N. C. Mo.
(e) Length of residence in city or town where death occurred yrs. mos. ds.

Registration District No. 359
Primary Registration District No. 1002 Registered No. 555
(d) Street No. General Hospital #2 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 2450 Walnut St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE Coloured 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-4, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from 1-31, 1939, to 2-4, 1939

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-26-1938

I last saw him alive on 2-4, 1939 Death is said to have occurred on the date stated above, at 3:10 P. M.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 9 8

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

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

Broncho-Pneumonia & Areas of Consolidation on the Right (Lower Lobe) Date of onset

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

Other contributory causes of importance: 1070

FATHER 13. NAME Kennis Rollins

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? no

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

MOTHER 15. MAIDEN NAME Faye Mooney

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)

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

Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____

17. INFORMANT (ADDRESS) Record Clerk

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) J. A. Purpus M. D.
(Address) General Hospital #2

18. BURIAL, CREMATION, OR REMOVAL PLACE Dillon DATE Feb 8 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. J. Fisher

20. FILED 9 1939 M. M. Brown Local Registrar

A. 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 hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, _____

Julius W. Tierlin

, or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Julius W. Tierlin

Licensed Embalmer No. 2239

P. O. Address 1212 Vine

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

If this body is not embalmed, above space should be left blank.