

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

Do not use this space.

1927

30665

1. PLACE OF DEATH

County Jackson Registration District No. 403
 Township Blue River Primary Registration District No. 5357 File No. _____
 City Lancaster City 79th & Blue Ridge Rd. Registered No. _____ (St. _____ Ward)

2. FULL NAME

(a) Residence. 79th & Blue Ridge Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 2 yrs. _____ mos. _____ ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M **4. COLOR OR RACE** wh **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 3, 1864

7. AGE YEARS 63 MONTHS 2 DAYS 11 IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Quincy
 (STATE OR COUNTRY) Ill.

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

14. INFORMANT Mrs. A. L. Sprout
 (Address) 79th & Blue Ridge

15. FILED _____, 19____
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) October 4 1927

17. I HEREBY CERTIFY, That I attended deceased from 10-11, 1927, to 10-14, 1927 that I last saw him alive on 10-10, 1927, and that death occurred, on the date stated above, at 2:15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchopneumonia
127
107A (duration) _____ yrs. _____ mos. 2 ds.
CONTRIBUTORY (SECONDARY) Cerebral Hemorrhage
 (duration) _____ yrs. _____ mos. 4 ds.

18. WHERE WAS DISEASE CONTRACTED? Home
 IF NOT AT PLACE OF BIRTH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

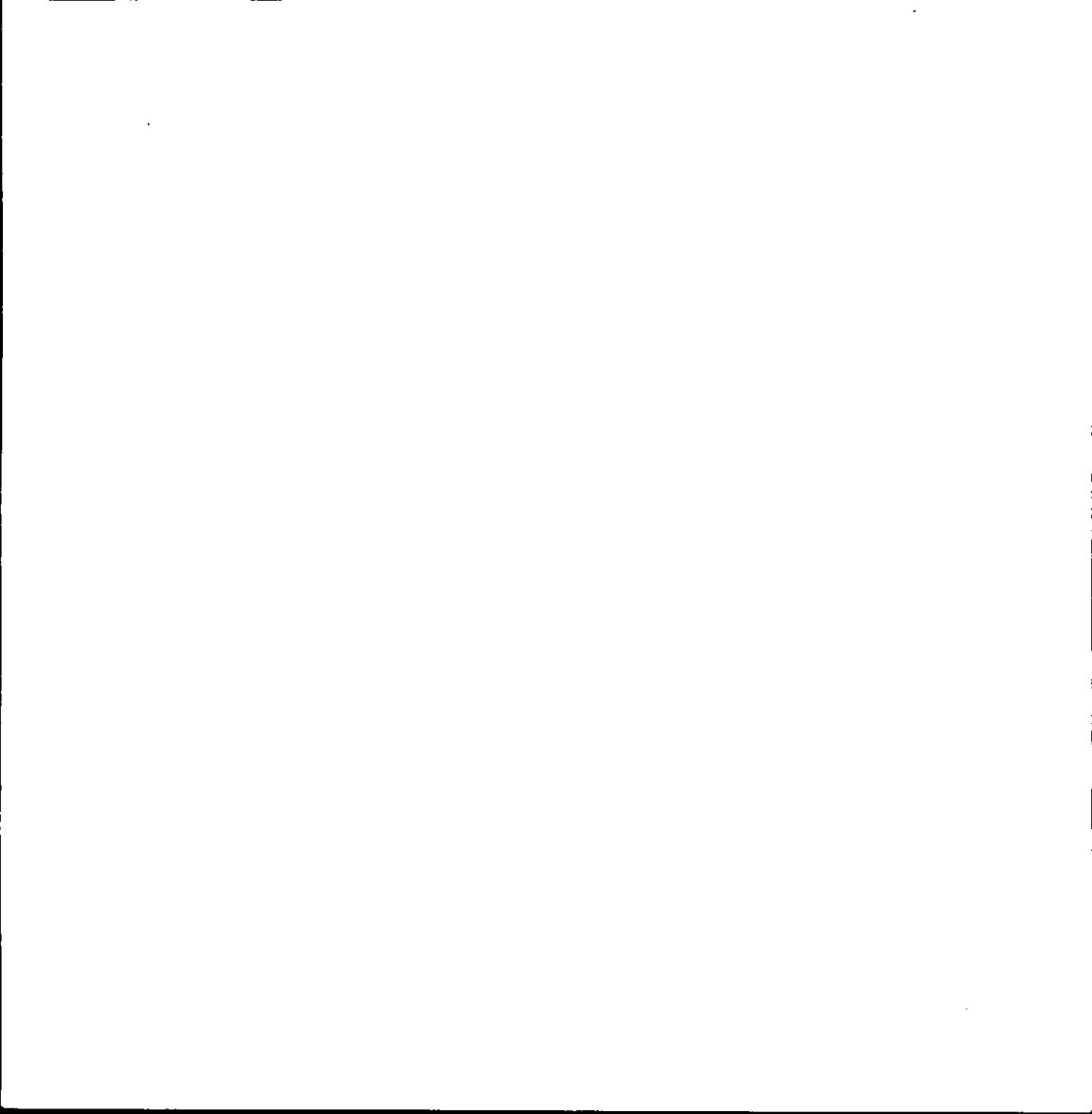
WHAT TEST CONFIRMED DIAGNOSIS? Physical signs
 (Signed) W. H. Stables, M. D.

10-14, 1927 (Address) Raytown, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. Calvary **DATE OF BURIAL** Oct. 17 1927

20. UNDERTAKER L. H. Newcomer's Sons ADDRESS _____



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Jackson Registration District No. 403 File No.
Township Blue Primary Registration District No. 5557 Registered No.
City (No.) St. Ward)

2. FULL NAME

John B. Jalkin

(a) Residence. No. St. Ward.
(Usual place of abode) (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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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

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

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED Oct 15 1927 W. W. Hobbs REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 14 1927

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19..... that I last saw h..... on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D. , 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-30665