

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

Do not use this space.

34806

1. PLACE OF DEATH

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City Louis (No. City Hospital)

File No. 19944

Registered No. 19944

St. _____ Ward)

2. FULL NAME

(a) Residence. No. 1766 Mississippi 23 Ward. _____
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Widowed

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 6 1927

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

17. I HEREBY CERTIFY That I attended deceased from Nov 3, 1927 to Nov 6, 1927 that I last saw him alive on Nov 6, 1927, and that death occurred, on the date stated above, at 9:20 a.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 17 - 1865

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Right upper lobe pneumonia

7. AGE YEARS MONTHS DAYS **IF LESS than 1 day, hrs. or min.**
62 1 20

CONTRIBUTORY (SECONDARY)
10 10 10 (duration) yrs. mos. da.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Ameswood.
(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) Kansas

10. NAME OF FATHER Sam Whitson

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

12. MAIDEN NAME OF MOTHER Mrs. Ross

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

14. INFORMANT (Address) Roman City Hospital

15. FILED NOV -7 1927 Man. b. Starckoff REGISTRAR

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) John Smith M. D.
, 1927 (Address) City Hospital

*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 Bellefontaine **DATE OF BURIAL** Nov 9 1927

20. UNDERTAKER Ashton Bellco 2707 N. Grand **ADDRESS**

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.

wood.