

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

Do not use this space.

17157

2129

**1. PLACE OF DEATH**

County Jackson  
Township Ray  
City Ray Mo (No. Dr Joseph Hospital)

Registration District No. 399  
Primary Registration District No. 100

File No. 2129  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. Dr Joseph Hos St. Ray Mo Ward. \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. How long in U.S., if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. \_\_\_\_\_

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 6 - 1923

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>4</u>	<u>6</u>	<u>6</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work none  
(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) Ray Mo

**10. NAME OF FATHER**

F M Barger

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Mo

**12. MAIDEN NAME OF MOTHER**

Jennie Patton

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Ray Mo

**14.**

INFORMANT F M Barger  
(Address) Ray Mo

**15.**

FILED 5/14/28 M. M. Crowe  
REGISTRAR user

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May - 12 19 28

17. I HEREBY CERTIFY, That I attended deceased from Apr 14, 1928, to May 12, 1928 that I last saw him alive on May 12, 1928, and that death occurred, on the date stated above, at 6:35 P m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Septic Meningitis  
8613

CONTRIBUTORY (SECONDARY) Acute Mastoiditis

9 weeks duration

18. WHERE WAS DISEASE CONTRACTED at his home,

IF NOT AT PLACE OF DEATH: \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? Yes DATE OF Apr 14 - 28

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Symptoms

(Signed) Ross H Underwood, M. D.

5/13, 19 28 (Address) 602 Argyle Bldg

\*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**

Ray Leo Pisgah, County Don't know

**20. UNDERTAKER**

**ADDRESS**

Habert Hope Est Springs

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.

