

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

Do not use this space.

35118

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **1003**

File No.
Registered No. **10100**
St. Ward)

2. FULL NAME

(a) Residence, No. **2818^a Kennerly** 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 **Male** | 4. COLOR OR RACE **White** | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Oct-26-1895**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	32	11	6	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **clerk**
(b) General nature of industry, business, or establishment in which employed (or employer) **Sellen Ward & Hasser**
(c) Name of employer

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

10. NAME OF FATHER **James Eunear**

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

12. MAIDEN NAME OF MOTHER **Mar M^e Queen**

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

14. INFORMANT **Viola Eunear**
(Address) **2818^a Kennerly**

15. FILED **OCT 15 1923** **May C Starke**
Registrar

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct 13 1928**

17. I HEREBY CERTIFY, That I attended deceased from **10**....., 19**28**, to **Oct 14**....., 19**28**
that I last saw **alive** on **Oct 14**....., 19**28**, and that death occurred, on the date stated above, at **7:30**..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute Lobar Pneumonia
108 10/10/28
(duration) yrs. mos. **8** ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) **Wm J. Jones**..... M. D.

10/13 19**28** (Address) **1727 Tappan**

*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 **S.S. Peter & Paul Cemetery** DATE OF BURIAL **10-16 1928**

20. UNDERTAKER **R. J. Ambuster Und.** ADDRESS **424 N. Euclid**

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.

WHITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

