

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

Do not use this space.

31682

1. PLACE OF DEATH

County St. Louis Registration District No. 735 File No. _____
 Township _____ Primary Registration District No. 3034 Registered No. 191
 City Moberly (No. St. Louis) St. Joseph Hospital St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 414 Washington St., Ward. _____
 (Usual place of abode)
 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) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 5th 1924

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, _____ hrs. or _____ min.
		<u>11</u>	<u>24</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (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) Mo

10. NAME OF FATHER Paul J. Nord

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Maries Maisterion

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo

(STATE OR COUNTRY)

14. INFORMANT J. V. Nord

(Address) St. Joseph Hosp.

15. FILED 10/3 19 1929 Dr. Thos. J. Fleming REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 29th 1929

17. I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1929, to Sept 29, 1929 that I last saw him alive on Sept 29, 1929, and that death occurred, on the date stated above, at 10:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Intussusception of bowel
1224

(duration) yrs. mos. 2 ds.

CONTRIBUTORY unknown (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF BIRTH _____

DID AN OPERATION PRECEDE DEATH? yes DATE OF Sept. 29

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS operation

(Signed) G. L. McCormick, M. D.

9-30, 1929 (Address) Moberly 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 _____ DATE OF BURIAL _____

St. Joseph Hosp. 7-5-29 1929

20. UNDERTAKER _____ ADDRESS _____

St. Joseph Hosp. Moberly Mo

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.

ST 24 1929

