

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

Do not use this space.

33041

1. PLACE OF DEATH

County Buchanan
Township St. Joseph
City State Hospital

85
Registration District No.
Primary Registration District No. 1001

File No.
Registered No. 1196
St. Ward)

2. FULL NAME

(a) Residence. No. State Hospital #2 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. 8 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) Unknown

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
50

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Unknown

PARENTS

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT J.C. McCamick
(Address) 6224 Perry Ave W.C. Mo.

15. FILED OCT 17 1929
John G. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 17 1929

17. I HEREBY CERTIFY That I attended deceased from Oct 9, 1929, to Oct 17, 1929, and that I last saw him alive on Oct 17, 1929, and that death occurred, on the date stated above, at 12.1 m. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
10X (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) 10/10 (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF.....
WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS.....
(Signed) J. P. Beach, M. D.
10-17-1929 (Address) State Hosp #2

*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 Cameron, Mo. DATE OF BURIAL Oct 19, 1929

20. UNDERTAKER Fleeman Funeral Home ADDRESS 1946 Lealhoum

WRITE PAINFULLY, 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.

1169

2831

612

