

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

Do not use this space.

36367

1. PLACE OF DEATH

County Buchanan
Township St Joseph
City St Joseph

Registration District No. 85
Primary Registration District No. 1001

File No. _____
Registered No. 1285
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred 4 yrs. _____ mos. _____ ds. How long in U.S., if of foreign birth? yrs. _____ mos. _____ ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 12, 1851

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
78 6 26

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Rockford Ill
(STATE OR COUNTRY)

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Mary Greenwood

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

14. INFORMANT Wm. B. Riche
Address 615 2015

15. FILED 8 1928 John L. [Signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2
16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 8 1929

17. HEREBY CERTIFY, That I viewed on Nov 8, 1929, to 1 that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 9-15A am.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephritis
131
97 / 290 (duration) 5 yrs. _____ mos. _____ ds.
CONTRIBUTORY # Arterio. Sclerosis
(SECONDARY) (duration) 5 yrs. _____ mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) W. T. Rock Coroner, M. D.
Address St Joseph 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 Union Chapel DATE OF BURIAL 11/10 1929

20. UNDERTAKER Heeman Funeral Home ADDRESS 1446 Colburn

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.

