

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

Do not use this space.

41321

1. PLACE OF DEATH

County Livingston Registration District No. 508
Township _____ Primary Registration District No. 3026
City Shillieste (No. _____) St. _____ Ward _____

File No. _____
Registered No. 117

2. FULL NAME

(a) Residence. No. _____ 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>Black</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Eva Hall</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Unknown</u>		
7. AGE	YEARS <u>75</u>	MONTHS <u>About</u>
	DAYS <u></u>	
	IF LESS than 1 day, _____ hrs. or _____ min.	
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>Laborer</u> (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) Unknown

PARENTS	10. NAME OF FATHER <u>Unknown</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Unknown</u>
	12. MAIDEN NAME OF MOTHER <u>Unknown</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>Unknown</u>

14. INFORMANT Mrs George Peris
(Address) Shillieste Mo.

15. FILED 12/31/29 Reuben Barney
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 1 1929
17. I HEREBY CERTIFY, That I attended deceased from Feb 29 1927 to Dec 1 1929 that I last saw him alive on 11/15/29, 1929, and that death occurred, on the date stated above, at 4:50 a.m.

131 THE CAUSE OF DEATH* WAS AS FOLLOWS:
130 B Nephritis
_____ (duration) / yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Uremia (duration) yrs. mos. 4 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 Wardlynes
(Signed) R. Collins M. D.
Dec 2 1929 (Address) Shillieste 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 Smith Colored Cemetery DATE OF BURIAL Dec 3 1929

20. UNDERTAKER G. M. Marshall ADDRESS Shillieste Mo

WRITE PAINLY, 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.

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