

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

Do not use this space.

13119

MAY 26 1930

PLACE OF DEATH *Kennel*

County *Warren* Registration District No. *1439*

Township *Walker Township* Primary Registration District No. *1*

City *Barnes* (No. *1*)

File No. \_\_\_\_\_

Registered No. *185*

St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME *Robert M. Stetson*

(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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

16. DATE OF DEATH (MONTH, DAY AND YEAR) *4-15* 19*30*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Nov 24 1909*

17. I HEREBY CERTIFY, That I attended deceased from *11-30* *1930* to *11-30-4-15-1930*, that I last saw h. *alive on* *19*, and that death occurred, on the *date stated above*, at \_\_\_\_\_ m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov 24 1909*

THE CAUSE OF DEATH WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *20 4 20*

*Killed by being struck by Santa Fe Freight train in attempting to catch a ride* (duration) yrs. mos. ds.

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. *R. R. Laborer* (b) General nature of industry, business, or establishment in which employed (or employer). \_\_\_\_\_ (c) Name of employer \_\_\_\_\_

CONTRIBUTORY (SECONDARY) *2:07 PM* *1880A* (duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) *Mo* (STATE OR COUNTRY) *Mocon Co, Mo*

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

10. NAME OF FATHER *Clara Stetson*

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

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

WAS THERE AN AUTOPSY? \_\_\_\_\_

12. MAIDEN NAME OF MOTHER *Callie Knecht*

WHAT TEST CONFIRMED DIAGNOSIS (Signed) *J. W. Hudson* CORONER *4-15-1930* (Address) *Edina Mo, Knox Co,*

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

14. INFORMANT *Mrs Jas Day* (Address) *Calced*

19. PLACE OF BURIAL CREMATION, OR REMOVAL *Held Chertan* DATE OF BURIAL *4/18 1930*

15. FILE *5/14 1930* *Edward Early* REGISTRAR

20. UNDERTAKER *Young* ADDRESS *St. Louis*

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.



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

ALL INFORMATION CALLED  
 FOR MUST BE WRITTEN ON  
 THIS SUPPLEMENTARY.

1. PLACE OF DEATH.  
 County Lenox Registration District No. 439 File No. ....  
 Township ..... Primary Registration District No. 4257 Registered No. 185-  
 City Boeing (No. ....) St. .... Ward) .....

2. FULL NAME Robert M. McInnis  
 (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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 24-1909

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
20 4 21

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) .....

10. NAME OF FATHER .....

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

12. MAIDEN NAME OF MOTHER .....

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

14. INFORMANT ..... (Address) .....

15. FILED 5/14 30 Edward E. Early REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/15-1930

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19..... that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
 ..... (duration) ..... yrs. .... mos. .... ds.  
 CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH.....  
 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....  
 WAS THERE AN AUTOPSY?.....  
 WHAT TEST CONFIRMED DIAGNOSIS?.....  
 (Signed)....., M. D.  
 , 19 (Address) .....

\*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 ..... 19.....

20. UNDERTAKER ..... ADDRESS .....

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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