

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

Do not use this space.

31313

1. PLACE OF DEATH

County.....

Registration District No. **701**

Township.....

Primary Registration District No. **1003**

City **Jordan** (No. **4545 Newberry**)

File No.

Registered No. **8913**

2. FULL NAME

(a) Residence. No. **4545 Newberry** St. **12** Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred **7 1/2** mos. **7** ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female **White** **married**

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

Roy Gasperson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Oct 30 - 1900**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	29	10	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. **Housewife**

(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**

PARENTS

10. NAME OF FATHER **J. F. Chumbley**

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

12. MAIDEN NAME OF MOTHER **Margaret Kidwell**

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

14. INFORMANT **Roy Gasperson**

(Address) **4545 Newberry**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Sept - 10 1930**

17. I HEREBY CERTIFY, That I attended deceased from **Aug 31 - 1930**, to **Sept - 10 - 1930** that I last saw **alive** on **Sept 10 - 1930** and that death occurred, on the date stated above, at **5:45 P.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
23A (duration) **2** yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH **Place of death**

DID AN OPERATION PRECEDE DEATH? **No.** DATE **9**

WAS THERE AN AUTOPSY? **No.**

WHAT TEST CONFIRMED DIAGNOSIS **Clinical symptoms**
(Signed) **Oren D. Cuddy** M. D.

Sept 7, 1930 (Address) **5088 Payne Blvd.**

*State the DISEASE CAUSING DEATH, or in death 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

Valhalla Care

Sept 13 1930

20. UNDERTAKER

ADDRESS

Fred M. Williams 4617 Delmar

15. SEP 12 1930 FILED

REGISTRAR

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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