

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

Do not use this space.

36478

1. PLACE OF DEATH

County Jackson Registration District No. 400 File No. _____
 Township Prairie Primary Registration District No. 355810 Registered No. 154
 City Lille River Mo (No. Jackson Co House) St. _____ Ward _____

2. FULL NAME

John Cleary
 (a) Residence No. Jackson Safety Home St. Ward _____ (If nonresident, give city or town and State)
 (Usual place of abode)
 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>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Single</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>6-19-1860</u>		
7. AGE	YEARS <u>70</u>	MONTHS <u>5</u>
	DAY <u>4</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) <u>unknown</u> (c) Name of employer <u>unknown</u>		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Illinois</u>		
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>	

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-23-1930

17. I HEREBY CERTIFY, That I attended deceased from 11-20-1930 to 11-23-1930
 that I last saw him alive on 11-22-1930, and that death occurred, on the date stated above, at 2 o'clock a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
mitoal resurgitation

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) MI
 (duration) _____ 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) J. D. Greene M. D.
1/24 1930 (Address) Independence 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 <u>Kirksville Colley</u>	DATE OF BURIAL <u>1/25 1930</u>
20. UNDERTAKER <u>Ketterlin</u>	ADDRESS <u>Kew</u>

14. INFORMANT J. W. Heister
 (Address) 12 House St
 FILED Nov 25 1930 H. S. Jam REGISTRAR

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.

WRITE PRINT, WITH OUTLINES

