

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

Do not use this space.

18149

1. PLACE OF DEATH

County Jackson
Township Ham
City H.C. No

Registration District No. 399
Primary Registration District No. 100
City (No. 1840 Belleme)

File No. _____
Registered No. 2291
St. _____ Ward)

2. FULL NAME

(a) Residence, No. 1840 Belleme St., 3 Ward.

(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>col</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>Mary White</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Dec 24 1890</u>		
7. AGE YEARS <u>40</u>	MONTHS <u>4</u>	DAYS <u>27</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.		If LESS than 1 day, hrs. or min.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) La

13. NAME Adams White

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) La

15. MAIDEN NAME unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) La

17. INFORMANT (ADDRESS) Mary White 1840 Belleme

18. BURIAL, CREMATION, OR REMOVAL PLACE West Lawn DATE 5-21 1921

19. UNDERTAKER (ADDRESS) H.B. Moore 1820 E. 18th H.C. No

20. FILED 5/20 1921 M.M. Crowe Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-19-21 19

22. I HEREBY CERTIFY, That I attended deceased from 4-2A-29, 1920, to 5-19-21, 1921

I last saw ~~him~~ alive on 5-18-21, 1921 Death is said

to have occurred on the date stated above, at 3:00 p.m.

The principal cause of death and related causes of importance were as follows:

Myocarditis, Sub acute
110 B
93 B / 10
106 B
Other contributory causes of importance:
chr. Bronchitis & pleurisy
Date of onset 1929

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 1921

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____

(Signed) Medley Faust M. D.
(Address) 750 Mumfords Ave. H.C. No.

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.

should read
S. C. A.

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

ALL INFORMATION RELAYED
 FOR MUST BE WRITTEN ON
 THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No. 2291
 City..... (No. 1849) Belleveur St. Ward.....

2. FULL NAME

G. W. White

(a) Residence. No. 1840 Belleveur 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
40

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 3/20 3 M. M. Croone REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/19 1931

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Myocarditis (subacute)

CONTRIBUTORY (SECONDARY) Ch. Bronchitis & pleurisy (duration) yrs. mos. da. (Do not know if pleurisy was TB.) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF BIRTH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPEY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) W. J. Faustman, 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

20. UNDERTAKER ADDRESS

N. F. Every item of information should be carefully 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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