

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

Do not use this space.

9608

1. PLACE OF DEATH

County Jackson
Township Jackson
City Jackson (No. 1210)

Registration District No. 389
Primary Registration District No. St. Marys Hospital

File No. _____
Registered No. 1210 Ward _____

2. FULL NAME

(a) Residence, No. 627 Frank St., _____ Ward.

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 11-1933

7. AGE YEARS 0 MONTHS 0 DAYS 1 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Infant
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) Kansas City Mo.

13. NAME Dennis G. M. Hart

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

15. MAIDEN NAME Leah DeKorn

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

17. INFORMANT (ADDRESS) Dennis G. M. Hart 3677 Grand St.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Marys DATE 3/13/33

19. UNDERTAKER (ADDRESS) F. O'Donnell 3756 Broadway

20. FILED March 17, 1933 M. M. Crowe

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 17 33

22. I HEREBY CERTIFY, That I attended deceased from 3/11/33 to 3/12/33, 1933
I last saw him alive on 3/12/33, 1933. Death is said to have occurred on the date stated above, at 9:30 P.
The principal cause of death and related causes of importance were as follows:

Prematurity.
Suprarenal gland
unimorphose
Other contributory causes of importance: _____
Date of onset _____

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

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
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? _____
If so, specify _____
(Signed) C. H. Smith, M. D.
(Address) MEMO.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE AND CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

