

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

Do not use this space.

24544

1. PLACE OF DEATH

County Jackson Registration District No. 339
 Township Jackson Primary Registration District No. 1000
 City St. Mo. (No. General Hospital #2 St. 3rd Ward)

File No. 3342
 Registered No. 3142

2. FULL NAME

(a) Residence, No. 2214 Spruce St., 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 Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower (Use the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-16-1878

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
56 4 5

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

MOTHER 13. NAME Julias Diggs

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

15. MAIDEN NAME Don't know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Do not know

17. INFORMANT (ADDRESS) Record Clerk General Hospital #2

18. BURIAL, CREMATION, OR REMOVAL PLACE Highland Cem. DATE July 17 1934

19. UNDERTAKER (ADDRESS) West Appleton Jones
1518 Mo.

20. FILED July 16, 1934 M. M. Crowe Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-15 1934

22. I HEREBY CERTIFY, That I attended deceased from 7-11, 1934, to 7-15, 1934
 I last saw him alive on 7-15, 1934 Death is said to have occurred on the date stated above, at 8:00 P.M.

The principal cause of death and related causes of importance were as follows:
Cerebral arteriosclerosis (Date of onset _____)

Softening of brain
 Other contributory causes of importance: Senile Dementia

Name of operation _____ Date of _____
 What test confirmed diagnosis? Chemical Was there an autopsy? No

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? No.
 If so, specify _____
 (Signed) O. Thomas M. D.
 (Address) General Hospital #2

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

AUG 21 1934

