

WRITE CLEARLY, 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.

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

Do not use this space.

OCT 11 1934

34086

1. PLACE OF DEATH

County.....
Township.....
City..... (No.) City..... (Ward).....

Registration District No. 791 ✓
Primary Registration District No. 1003

File No.....
Registered No. 8858
St. Ward.....

2. FULL NAME

(a) Residence, No. 6906 Palms St. 4 Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M	4. COLOR OR RACE W	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) Jan 17 - 1910		
7. AGE	YEARS 19	MONTHS 7
	DAYS 16	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Mil 1.55	
	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	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-3 1934

22. I HEREBY CERTIFY, That I attended deceased from 4:12, 1934, to 9-3, 1934. I last saw him alive on 9-3, 1934. Death is said to have occurred on the date stated above, at 4:10 P.M.

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

Chronic Osteomyelitis of Right Femur

Other contributory causes of importance:

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

MOTHER FATHER

13. NAME John Smith

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

15. MAIDEN NAME Sarah Wood

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

17. INFORMANT (ADDRESS) Hospital at St. Joseph

18. BURIAL, CREMATION, OR REMOVAL PLACE (ADDRESS) New St. Marys DATE 9-6-34

19. UNDERTAKER (ADDRESS) The Catholic Burial Society 422 1/2 N. 1st St. St. Joseph, Mo. J. P. Brucke Registrar.

20. FILED 19.....

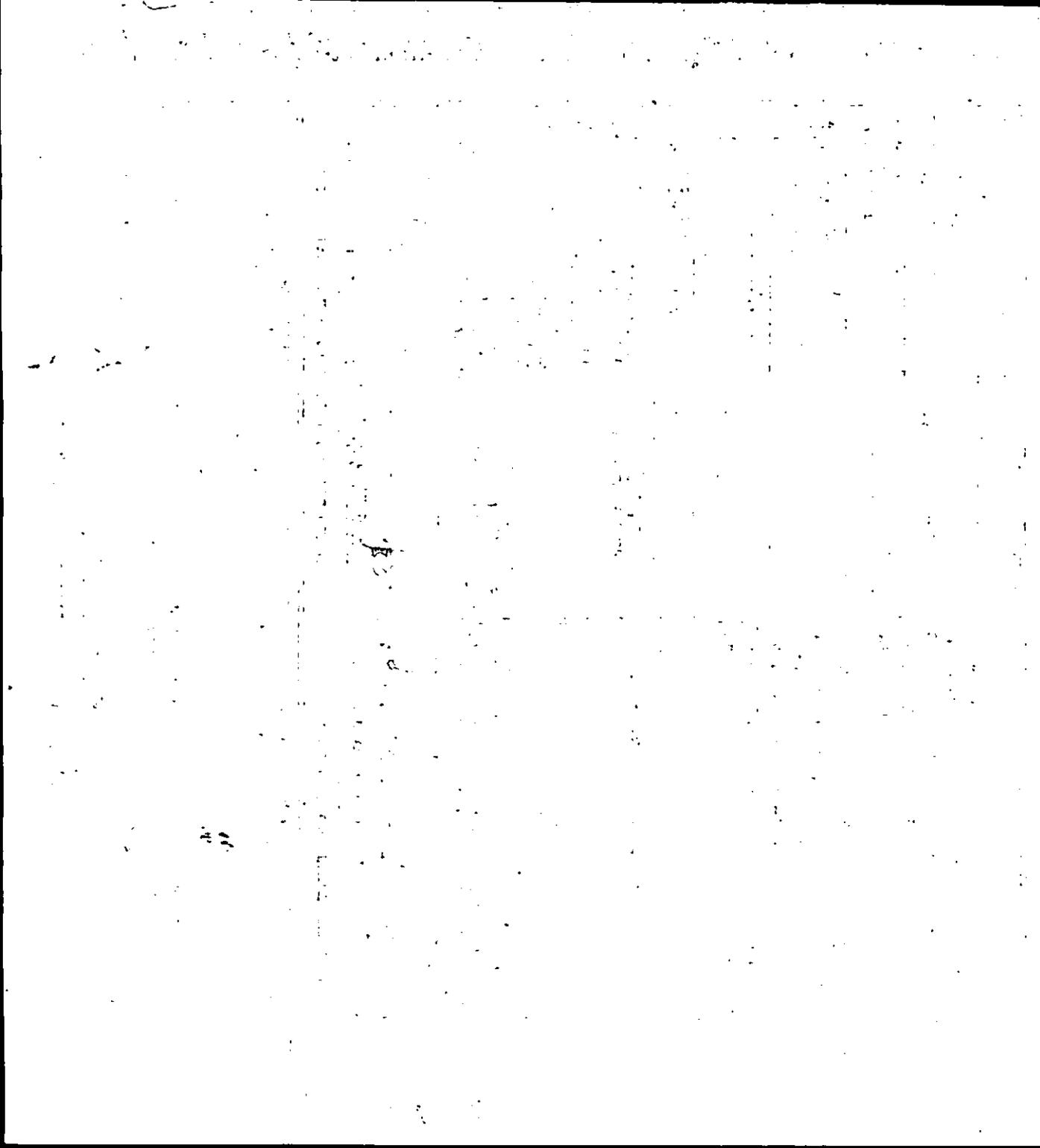
Date of onset

Name of operation Prostomy Date of 5/24/34
What test confirmed diagnosis? Date of 7/19/32
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?
If so, specify.....
(Signed) R. B. Siegel, M. D.
(Address) City Hospital



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

**791
1008**

1. PLACE OF DEATH

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City.....

(No.)

City Hospital

St.

Ward)

File No.
Registered No. 8838

2. FULL NAME

(a) Residence, No.

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 L 4. COLOR OR RACE N. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S.
(Write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-17-1916

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>19</u>	<u>7</u>	<u>16</u>	

8. Trade, profession, or particular kind of work done, as splinner, sawyer, bookkeeper, etc.....

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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19.....

19. UNDERTAKER (ADDRESS)

20. FILED 3-21-35 J. A. Bredek Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-3-1934

22. I HEREBY CERTIFY, That I attended deceased from 4:12 to 9-3-1934

I last saw him alive on 9-3-1934 Death is said to have occurred on the date stated above, at 4:10 p.m.

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

Chylosteomyelitis of right femur
Unknown as to tubercular
traumatic - Cause unknown
Other contributory causes of importance.....

Name of operation Osteotomy Date of 5-24-34

What test confirmed diagnosis? 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?.....

If so, specify.....

(Signed) P. B. Sargent M. D.
(Address) City Hospital

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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