

BEG'D APR 17 1939

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

9606
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson Registration District No. 399
(b) Township 13th NW Primary Registration District No. 1002
(c) City H.E. MO (d) Street No. H.E. Gen Hosp Registered No. 1212 St.
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME 320 Donald Pathog
(a) Residence, No. H.E. Circle St. (Usual place of abode, if no street address, write county or city) (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 Infant
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March-3-39
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 13
OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Infant
9. Industry or business in which work was done, as 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) H.E. MO
FATHER 13. NAME unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown
MOTHER 15. MAIDEN NAME unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown
17. INFORMANT (ADDRESS) Record Clerk H.E. Gen Hosp
18. BURIAL, CREMATION, OR REMOVAL Lead Cmt. DATE 3-20-39
19. FUNERAL DIRECTOR (NAME) (ADDRESS) John B. Ferguson 536 Campbell
20. FILED Mar 20, 1939 M.M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-16-39
22. I HEREBY CERTIFY, That I attended deceased from 3-14-39, 1939, to 3-16-39.
I last saw him alive on 3-16-39 Death is said to have occurred on the date stated above, at 7:30 p.m.
The principal cause of death and related causes of importance were as follows:
Bilateral Bronchopneumonia
Secondary 1198
Other contributory causes of importance: Marasmus and Intero Colitis
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) P. J. De Maner, M. D.
(Address) General Hosp

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, _____
_____, or by _____
Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.