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

897

PLACE OF DEATH

County Greene

Township ____ or Village ____ or City Springfield (No. Springfield Hosp St.; ____ Ward)

Registration District No. 318 Primary Registration District No. 2001 File No. ____ Registered No. 1

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Joseph adams

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Unknown

DATE OF BIRTH Unknown (Month) ____, 1 (Day) ____ (Year)

AGE About 50 yrs. ____ mos. ____ ds. If LESS than 1 day, ____ hrs. or ____ min:?

OCCUPATION
(a) Trade, profession, or particular kind of work ____
(b) General nature of industry, business, or establishment in which employed (or employer) ____

BIRTHPLACE (City or town, State or foreign country) Unknown

PARENTS
- NAME OF FATHER Unknown
- BIRTHPLACE OF FATHER (City or town, State or foreign country) Unknown
- MAIDEN NAME OF MOTHER Unknown
- BIRTHPLACE OF MOTHER (City or town, State or foreign country) Unknown

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ____

(ADDRESS) Eb Payne, SPRINGFIELD

Filed JAN 1 1917 191 ____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Jan 1 — (Month) (Day) 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from July 1, 1916, to Dec 31, 1916, that I last saw h~~e~~m alive on Dec 31, 1916, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Sclerosis of Coronary Artery with Cardiac hypertrophy

94B

95F

111A

(Duration) 1 yrs. ____ mos. ____ ds.

Contributory (Secondary) Terminal pneumonia

(Duration) ____ yrs. ____ mos. 2 ds.

(Signed) W E Handley M. D.

1/1 191 7 (Address) Springfield Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL Rozelwood Cem. DATE OF BURIAL 1-2- 1917

UNDERTAKER Pearson and Co. ADDRESS Springfield Mo

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

PLACE OF DEATH

County.....

Township ..... or Village ..... or City .....

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

(NO. ..... St.: ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1..... (Month) (Day) (Year)

AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

OCCUPATION

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE (City or town, State or foreign country) .....

PARENTS

NAME OF FATHER .....

BIRTHPLACE OF FATHER (City or town, State or foreign country) .....

MAIDEN NAME OF MOTHER .....

BIRTHPLACE OF MOTHER (City or town, State or foreign country) .....

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191....., ...

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h..... alive on ....., 191....., and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration).....yrs.....mos.....ds.

(Signed) ..... M. D.

..... 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191.....
UNDERTAKER	**ADDRESS**