

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

45457

1. PLACE OF DEATH

County Greene Registration District No. 318 File No. _____
 Township _____ Primary Registration District No. 2001 Registered No. 894
 City Springfield, Mo. (No. 645) Normal Ave St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 645 Normal Ave St. 1st Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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) Nov 19 1918

7. AGE YEARS MONTHS DAYS IF LESS than 1 day hrs. min. 16 2 4 16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home Infant
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Springfield
 (STATE OR COUNTRY) Mo

10. NAME OF FATHER Frank Logan

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ill
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mamie Farris

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ill
 (STATE OR COUNTRY)

14. INFORMANT Frank Logan
 (Address) Springfield, Mo

15. DEC 5 1918 Filed _____
 _____ Registrar
 _____ Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 5th 1918

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 4 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1. Premature Birth
2. Heart malfunction

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) Chy. Johnson, M.D.

12-5-1918 (Address) Springfield Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Maple Park Cem DATE OF BURIAL 12-5-1918

20. UNDERTAKER Johnson Lumber Co ADDRESS 400 South St.

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.

