

MAR 24 1927

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

Do not use this space.

4529

1. PLACE OF DEATH

County Ingram

Registration District No. 318

File No. 1

Township Springfield

Primary Registration District No. 2001

Registered No. 134

City Springfield (No. 904 W. Madison) St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 904 W. Madison St. _____ 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. 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) child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-26-27

7. AGE YEARS MONTHS DAYS If LESS than 1 day, 8 hrs. or 30 min.

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work child (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

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

10. NAME OF FATHER Charles Thompson

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

12. MAIDEN NAME OF MOTHER Miss Dutton

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

14. INFORMANT Charles Thompson (Address) 904 W. Madison

15. FILED 2/28/27 OCT 27 1927 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-26-27

17. I HEREBY CERTIFY That I attended deceased from 2-26-27 to 2-26-27 that I last saw him alive on 2-26-27 and that death occurred, on the date stated above, at 7:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Heart known ministers 159

CONTRIBUTORY (SECONDARY) 205 B (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____ WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) [Signature] M. D. 2/28/27 (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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL East Lawn DATE OF BURIAL 2/27/27

20. UNDERTAKER [Signature] ADDRESS [Signature]

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.

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