

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

Do not use this space.
11420

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.

MAY 27 1927

1. PLACE OF DEATH

County Franklin
 Township Springfield
 City Springfield

Registration District No. 318
 Primary Registration District No. R. 1. D. 55440

File No. _____
 Registered No. 221
 St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Madison J. Terrell St. _____ Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 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) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 23 - 1901

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
25 - 6 - 4

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farmer
 (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 W. S. Terrell

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

12. MAIDEN NAME OF MOTHER Julia Paris

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

14. INFORMANT (Address) W. S. Terrell
Springfield Mo.

15. FILE NO. 47-270 REGISTRAR O. C. Host

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4 - 6 - 1927

17. I HEREBY CERTIFY That I attended deceased from 4 - 6 - 1927 to 4 - 6 - 1927
 that I last saw h. alive on 4 - 6 - 1927, and that death occurred, on the date stated above, at 4 10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute dilatation of heart

CONTRIBUTORY (SECONDARY) NO
 (duration) yrs. mos. ds.

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

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

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) W. S. Terrell M. D.
4-7-1927 Address Springfield Mo.

*State the DISEASE CAUSING DEATH, or its results from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
South Springfield 4 - 10 - 27

20. UNDERTAKER W. S. Terrell ADDRESS Springfield Mo.

