

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

Do not use this space.

41461

1. PLACE OF DEATH

County Greene

Registration District No. 318

Township Springfield

Primary Registration District No. 2091

City Springfield

No. 1817 Washington

File No.

Registered No. 271

St. Ward)

2. FULL NAME

(a) Residence. No. 1817 Washington 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 24 - 1856

7. AGE YEARS 90 MONTHS 11 DAYS 6 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Ohio

(STATE OR COUNTRY)

10. NAME OF FATHER John Lester

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ohio

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Campbell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ohio

(STATE OR COUNTRY)

14.

INFORMANT

(Address) Springfield, Mo.

15.

File 4/30-27 CC Forest M

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-30-1927

17.

I HEREBY CERTIFY, That I attended deceased from 3-29-1927 to 4-30-1927
that I last saw her alive on 4-29-1927, and that death occurred, on the date stated above, at 4-30-1927 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senility

CONTRIBUTORY (SECONDARY) 164

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) C. E. Zeller, M. D.

4-30-1927 (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.

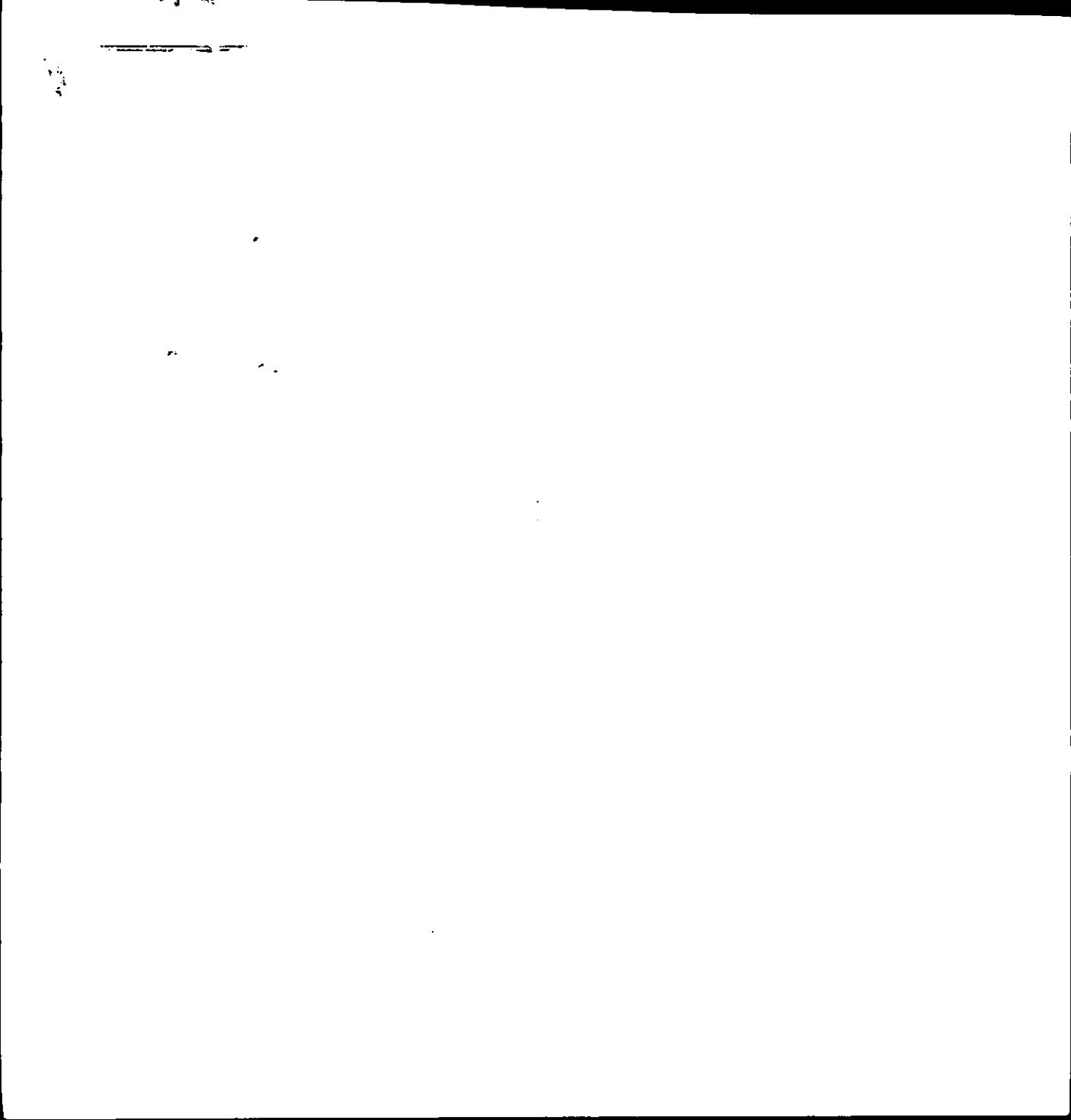
19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Wesley Chapel Cemetery 1927

20. UNDERTAKER

Wicklingner & Co 4246-Com

ADDRESS Springfield, Mo



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

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1. PLACE OF DEATH

County Greene
Township Campbell
City Campbell

Registration District No. 318
Primary Registration District No. 2001

File No.
Registered No. 271
St. Ward)

2. FULL NAME

(a) Residence. No. 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX D 4. COLOR OR RACE H 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

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

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER Anderson Campbell

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

14. INFORMANT (Address)

15. FILED 4/30/87 October 1987 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 30 1927

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., (duration) yrs. mos. da. that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

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)....., M. D. , 19 (Address)

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

19

S-11461