

27 1927

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

Do not use this space.

14772

1. PLACE OF DEATH

County Greene

Registration District No. 318

Township Springfield

Primary Registration District No. 2001

City Springfield

(No. 901 E. Brower)

File No. _____

Registered No. 281

St. _____, Ward _____

2. FULL NAME

(a) Residence. No. 901 E. Brower

Ward _____

(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

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Thos E. Pruitt

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

March 2 - 1875

7. AGE

YEARS 52

MONTHS

2

DAY

4

IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

House wife

(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

John Denny

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

14. INFORMANT

(Address) Thos E. Pruitt, Springfield, Mo.

15. FILED

5/7/27 Oct 1st 1927

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

May 6 1927

17.

I HEREBY CERTIFY, That I attended deceased from Jan 6 1927, to May 6 1927 that I last saw her alive on May 6 1927 and that death occurred, on the date stated above, at _____

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1111 Influenza
1144

CONTRIBUTORY (SECONDARY)

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

(duration) 2 yrs. 6 mos. 6 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

at place of death

DID AN OPERATION PRECEDE DEATH? no. DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) J. A. Britton, M. D.

May 7 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

Hamington Cemetery May 9 1927

20. UNDERTAKER

ADDRESS

J. W. Kingner 26424 E. 4th St
Springfield, Mo.

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.

STATE

of

IN

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Greene Registration District No. 318 File No.
 Township Primary Registration District No. 2001 Registered No. 281
 City Springfield 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

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

14.

INFORMANT
 (Address)

15.

FILED 577 1927 October 11
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY That I attended deceased from 19, 19, that I last saw h..... alive on, 19, and that death occurred, on the date stated above.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Supplemental
Acute infection not tubercular
no trauma
 CONTRIBUTOR (SECONDARY) *phases of lung*
 (duration) yrs. mos. da.

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, or HOMICIDAL.

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

20. UNDERTAKER ADDRESS

THIS IS A SUPPLEMENTARY RECORD

Every form of information should be carefully compiled. 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.

THIS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

KS-14772