JUN 27 1927

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

Do not use this space.

14825

1. PLACE OF DEATH
County Greene — Registration District No. D. Rinehart 318
Township — Primary Registration District No. 5439
City Springfield — (No. County Farm St. Ward)

File No.
Registered No. 276

2. FULL NAME C. R. Cardwell
(a) Residence. No. County Farm St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 1 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): married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 1847

7. AGE: Years 80 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Don't know
(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.

PARENTS
10. NAME OF FATHER: Don't know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Don't know
12. MAIDEN NAME OF MOTHER: Don't know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Don't know

14. INFORMANT: Mr Bradshaw
(Address) County Farm

15. FILED 5/6 1927 O C Horst Mo
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 5-5-1927

17. I HEREBY CERTIFY, That I attended deceased from 2-21, 1927, to 5-5-1927, that I last saw h[illegible] alive on 5-4-1927, and that death occurred, on the date stated above, at 11 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arterio-Sclerosis
92 A
97
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Mitral Regurgitation
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Yes
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J S Rinehart M.D.
5/6, 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: Hazelwood CEMETERY
DATE OF BURIAL: 5-7-1927

20. UNDERTAKER: W. Marvin
ADDRESS: Wilson Mark 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

MISSOURI STATE BOARD OF HEALTH
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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 N Campbell Primary Registration District No. 5439 Registered No. 276

City ..... (No. ..... St. ..... Ward)

2. FULL NAME C. R. Cardwell

(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. 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) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown X1847

7. AGE YEARS 80 MONTHS Unknown 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)

PARENTS

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 5/6, 1927 O C Horst M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 5 1927

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 ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

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

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) ....., 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 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

N. B.—Every [illegible] information should be carefully supplied. AGE should be stated [illegible] PE [illegible] should state CAUSE OF DEATH [illegible] plain terms, so that it may be properly classified. Exact statement of [illegible] important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE - RESCIN[illegible]D BY LAW

5-14825