SEP 28 1927

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

Do not use this space. See Cox

24074

1. PLACE OF DEATH
County Greene — Registration District No. 318 — File No.
Township — Primary Registration District No. 2001 — Registered No. 492
City Springfield (No. 811 N. Nettleton St. Ward)

2. FULL NAME Mrs. Alice Schofield
(a) Residence. No. 811 N. Nettleton 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 F.
4. COLOR OR RACE Wh.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF T. J. Schofield

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 22 1864

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
63	6	17	

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

9. BIRTHPLACE (CITY OR TOWN) Houston
(STATE OR COUNTRY) Texas

PARENTS
10. NAME OF FATHER James Hix
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ind.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Julia York
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ohio
(STATE OR COUNTRY)

14. INFORMANT Mrs. E. R. Ray
(Address) 804 W. Olive

15. FILED 8/10 1927 O. C. Horst Mr. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/9 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 2, 1927, to to Aug 9, 1927 that I last saw her alive on 8/2 1927, and that death occurred, on the date stated above, at 5 55 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

TBA Tuberculosis of Lungs

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 31

(duration) 3 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
8 DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Lu Cox, M. D
8/10, 1927 (Address) 223½ South

*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 Maple Park — DATE OF BURIAL 8/10 1927

20. UNDERTAKER Alma Lohmeyer — ADDRESS SPRINGFIELD, MO. F. H.

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.