

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

26962

1. PLACE OF DEATH

County Greene

Registration District No. 318

Township Springfield

Primary Registration District No. 2001

City Springfield

(No. 1010 E. Grand St.)

File No. _____

Registered No. 553

St. _____

Ward _____

2. FULL NAME

(a) Residence. No. 1010 E. Grand St., _____ Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 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

W

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

widow

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

Benjamin J. Spear

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

Jan 22 1879

7. AGE

YEARS 80

MONTHS 9

DAYS 19

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

8. OCCUPATION OF DECEASED

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

Housewife

(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)

ma

10. NAME OF FATHER

Barney Tabor

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Penn

12. MAIDEN NAME OF MOTHER

Mary Anderson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

mo.

14.

INFORMANT

(Address)

Jose W. Spear
1010 E. Grand St.

15.

FILE

9/12 27 Ob. Horst me

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

9-11-27

17.

I HEREBY CERTIFY That I attended deceased from July 15, 1927, to 9-11-27, 1927 that I last saw her alive on 9-11-27, and that death occurred, on the date stated above, at 3:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

cardio-vascular degeneration

930

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

CONTRIBUTORY (SECONDARY)

900

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Joseph D. Jones M. D.

12 (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

Springfield Kansas

9-13 27

20. UNDERTAKER

W. Horne

Springfield

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.

DEPARTMENT RECORD

1963