

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

26976

1. PLACE OF DEATH

County *Greene* Registration District No. *318*

File No. *570*

Township *Springfield* Primary Registration District No. *2001*

Registered No. *570*

City *Springfield* (No. *939*) *W. Webster* St. (Ward)

2. FULL NAME

(a) Residence. No. *929 W. Webster* St., Ward. *Infant daughter of Mrs. Leta Hammond*

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 *♀* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Infant*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 18 - 1927*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *0 0 0*

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work *Infant* (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) *Missouri*

10. NAME OF FATHER *Leta Hammond*

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

12. MAIDEN NAME OF MOTHER *Leta Holstein*

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

14. INFORMANT *Leta Hammond* (Address) *Springfield Mo*

15. FILE NO. *918 27* REGISTRAR *Oct 1st 1927*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 18 1927*

17. I HEREBY CERTIFY, That I attended deceased from *9-18-27* to *9-18-27* that I last saw h. *alive on 9-18-27* and that death occurred, on the date stated above, at *m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS: *Congenital Heart Disease*

1576 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? *no*

DID AN OPERATION PRECEDE DEATH? *no* DATE OF

WAS THERE AN AUTOPSY? *no* WHAT TEST CONFIRMED DIAGNOSIS? *Clinical symptoms* (Signed) *Henry T. Knapp* M. D.

(Address) *500 1/2 E. Conil*

*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 *Highlandville Mo* DATE OF BURIAL *Sept 18 1927*

20. URBERTAKER *J. W. Klingner & Co* ADDRESS *Springfield Mo*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

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**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
Township Springfield
City Springfield

Registration District No. 318
Primary Registration District No. 2001

File No. _____
Registered No. 3-70
St. _____ Ward _____

2. FULL NAME

(Infant) Hammond
(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)
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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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. 1 hr.

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 9/18 27 October 1927 REGISTERAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 18 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:

Congenital heart disease
due to my heart I know X
(duration) _____ yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 154B
(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. (See reverse side for additional space.)

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

20. UNDERTAKER _____ ADDRESS _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED

CRUSE OF DEATH in plain terms, so that it may be properly classified. Exact statistical classification should also be given.

DEATH RECORD

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