

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

Do not use this space.

26983

1. PLACE OF DEATH

County Greene
Township Springfield
City Springfield (No. 119 E Division)

Registration District No. 318
Primary Registration District No. 119 E Division

File No. _____
Registered No. 577
St. _____ Ward _____

2. FULL NAME

(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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 25 - 1885

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. _____ min.
75 6 29

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) N.Y.
(STATE OR COUNTRY)

10. NAME OF FATHER Wm. W. Dailey

11. BIRTHPLACE OF FATHER (CITY OR TOWN) N.Y.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary E. Dailey

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

14. INFORMANT Mrs. Understate
(Address) Springfield, Mo.

15. FILED 9/24 1927 Octhorst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/24 1927

17. I HEREBY CERTIFY, That I attended deceased from 9/22/27 to 9/24/27 19. 27 that I last saw her alive on 9/24/27 19. 27, and that death occurred, on the date stated above, at 12:10 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Broncho Pneumonia Primary
131
131A
117 Senility
CONTRIBUTORY (SECONDARY) Chronic Nephritis
131
131A
117 Senility
131
131A
117 Senility

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH, _____

IF AN EPIDEMIC PRECEDE DEATH, _____ DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) Octhorst M. D.

9/24, 1927 (Address) Springfield Mo

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Green Lawn Cem. DATE OF BURIAL Sep 25 1927

20. UNDERTAKER W. H. Ingner & Co. ADDRESS Springfield, Mo.

PERMANENT RECORD - 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.

