

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

Do not use this space.

26985

1. PLACE OF DEATH  
County Greene Registration District No. 318  
Township Angels mo Primary Registration District No. 2001  
City (No.) \_\_\_\_\_ Registered No. 589  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Wesley Denny  
(a) Residence. No. Greene mo 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 Male  
4. COLOR OR RACE White  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 27 - 1857

7. AGE YEARS MONTHS Days If LESS than 1 day, hrs. min.  
75 \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

8. OCCUPATION OF DECEASED Merchant  
(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 Wesley Denny  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_  
12. MAIDEN NAME OF MOTHER Dutton  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) \_\_\_\_\_

14. INFORMANT Wesley Denny  
(Address) Greene mo

15. FILED 9/27 1927 Oct 1st 1927  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY That I attended deceased from Sept 21 1927 to Sept 24 1927 that I last saw him alive on Sept 24 1927 and that death occurred, on the date stated above, at 6:30 P m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Fract. Skull (Basal)  
Fract. Femur

2:10 AM (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) 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) Harris Smith, M.D.  
, 19 \_\_\_\_\_ (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 \_\_\_\_\_

20. UNDERTAKER Wesley Denny ADDRESS \_\_\_\_\_

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY.

Imported  
from the  
United States

should be called MEXICAN. BYE  
Department of OCCUPATION

Applied  
1917

**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. 380  
St. .... Ward)

**2. FULL NAME**

Chas. V. Denny

(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)

7. AGE YEARS MONTHS 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)

**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

9/27 27 October 1927  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

17. I HEREBY CERTIFY, That I attended deceased from ..... to ..... 19....., and that I last saw him ..... alive ..... 19....., and that death occurred, on the date stated above, at..... m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Fract. Skull (Basal)  
Fractured femur  
Struck by auto mobile at Ava Mo

**CONTRIBUTORY (SECONDARY)**

**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**

19

**20. UNDERTAKER**

**ADDRESS**

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION, if very important.

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

SUPPLEMENTARY

5877