

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

Do not use this space.

33215

1. PLACE OF DEATH

County Greene Registration District No. 318
 Township Springfield Primary Registration District No. 2001
 City Springfield (No. 1625 E. Florida) St. Mo. Ward

File No. _____
 Registered No. 687

2. FULL NAME

(a) Residence. No. 1625 E. Florida St. Mo.
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 31 - 1907

7. AGE YEARS 20 MONTHS 5 DAYS 10 If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Ohio
 (STATE OR COUNTRY)

10. NAME OF FATHER Frank L. Dellinger

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

12. MAIDEN NAME OF MOTHER Ada M. Schouten 11-12-1927 (Address) Springfield Mo.

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

14. INFORMANT F. L. Dellinger
 (Address) Springfield Mo.

15. FILED 11/12/27 1927 O. O. Horst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-11-1927

17. I HEREBY CERTIFY, That I attended deceased from 7-23-1927, to 11-11-1927, that I last saw him alive on 11-10-1927, and that death occurred, on the date stated above, at 10 10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary T.B.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ da.

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) C. P. Fuller, M. D.

*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 Timber Ridge Cemetery DATE OF BURIAL Nov. 13 1927

20. UNDERTAKER W. Klingner & Co ADDRESS 424 E. 6th Springfield Mo.

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.

MISSOURI STATE BOARD OF HEALTH

1928

