

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

Do not use this space.

33247

1928
JAN 11
PLACE OF DEATH
Greene

County Greene

Registration District No. 318

Township Springfield

Primary Registration District No. 2001

City Springfield (No. 2006 N.)

Wheaton

File No. _____

Registered No. 727

St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 2006 N. Wheaton 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. 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) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 15 - 1848

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
79 | 8 | 15

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) Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER James Bayless

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Mrs. Alice Long
(Address) Springfield, Mo.

15. FILED 12/1 1927 October Mo.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-30 1927

17. I HEREBY CERTIFY, That I attended deceased from 11-20-27, 1927, to 11-30-, 1927 that I last saw her alive on 11-29-, 1927, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1928
1000
Primary
Primary (duration) yrs. mos. da. 3 da.

CONTRIBUTORY (SECONDARY) Senility (duration) yrs. mos. da. 1 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED 1000
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) C. P. Feller, M. D.

11-30, 1927 (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 Cuba Mo. DATE OF BURIAL Dec 20 1927

20. UNDERTAKER W. Klingner Co. 424 6th ADDRESS 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.

THIS IS A PERMANENT RECORD

