

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

Do not use this space. 743

FEB 21 1928

1. PLACE OF DEATH

County Greene Registration District No. 318

Township \_\_\_\_\_ Primary Registration District No. 2001

City \_\_\_\_\_ (If nonresident give city or town and State)

File No. \_\_\_\_\_  
Registered No. 827  
Hospital \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

(a) Residence. No. 2001 St. 2nd 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.

PERSONAL AND STATISTICAL PARTICULARS

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

Male White Married

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

Wife of deceased

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

July 18 - 1881

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

46 5 19

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Business  
(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)

Calif

10. NAME OF FATHER

Long address

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

Calif

12. MAIDEN NAME OF MOTHER

Sparks

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

Mo

14. INFORMANT

Wife of deceased

(Address) Greene

15. FILED

17, 1928 October 1st

REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 7, 1928

17. I HEREBY CERTIFY That I attended deceased from Jan 6, 1928, to Jan 7, 1928 that I last saw him alive on Jan 5, 1928, and that death occurred, on the date stated above, at 6 am.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Heart  
gangrenous appendicitis  
121A  
124 (duration) yrs. mos. 7 ds.  
CONTRIBUTORY General peritonitis (SECONDARY) (duration) yrs. mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF BIRTH Seaboard Mo

DID AN OPERATION PRECEDE DEATH? Yes DATE OF Jan 6-27

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

Spec

(Signed) Emmerich, M. D.

(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 DATE OF BURIAL

Springfield Mo 1 1928

20. UNDERTAKER ADDRESS

Springfield, Mo

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

State of

County of

vs.

CAUSE NO. 123456789  
Every item of information should be carefully supplied

10/10/10

**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

Registration District No. 218

File No. 7

Township SPRINGFIELD

Primary Registration District No. 2001

Registered No. 7

City SPRINGFIELD

St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** W. P. Russell

(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 M (write the word)

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) \_\_\_\_\_

**PARENTS**  
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 1-7-28 Oct Hunt REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 7 19 28

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 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:

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

\_\_\_\_\_ (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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. DEATH in ph. 10. 19. 28. so that it may be properly classified. TRANS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

*[Signature]*  
ADDRESS \_\_\_\_\_

S-743