

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

Do not use this space.

761

1. PLACE OF DEATH

County Greene
Township Springfield
City Springfield

Registration District No. 318
Primary Registration District No. 2906
No. St. Johns Hospital

File No.
Registered No. 28
St. Ward)

2. FULL NAME

(a) Residence. No. St. Ward. Fair View 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

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) Dec 16 - 1879

7. AGE Years MONTHS DAYS If LESS than 1 day, hrs. or min.
48 0 27

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) (STATE OR COUNTRY) Mo.

10. NAME OF FATHER John Davidson

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

12. MAIDEN NAME OF MOTHER Mary Harroll

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

14. INFORMANT Oren Davidson
(Address) Springfield Mo

15. FILED 1/13 28 DeForest Mo. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/13 19 28

17. I HEREBY CERTIFY, That I attended deceased from Dec 25, 1927, to Jan 13, 1928, that I last saw him alive on Jan 12, 1928, and that death occurred, on the date stated above, at 9 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Encephalitis

78 B / 10 B (duration) yrs. 12 mos. ds.

CONTRIBUTORY (SECONDARY) Exhaustion (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Fair View Mo
IF NOT AT PLACE OF DEATH St. Johns Hospital

DID AN OPERATION PRECEDE DEATH? No DATE OF Dec 27-29

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Smear
(Signed) Dr. Smith, M. D.
1/13, 19 28 (Address) Springfield

*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
Rocky Comfort Mo. Jan 14 19 28

20. UNDEERTAKER White Undertaking Co. ADDRESS Fair View 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.

21 1928

