

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

Do not use this space.

8571

1. PLACE OF DEATH

County Greene

Registration District No. 318

File No. \_\_\_\_\_

Township Springfield

Primary Registration District No. 2031

Registered No. 223

City Springfield (No. 2031)

Ward Boonville

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

2. FULL NAME

(a) Residence. No. 2031 Boonville St. \_\_\_\_\_

Ward \_\_\_\_\_

(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 (use the word)

single

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

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

Aug 11 - 1927

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

0

7

15

8. OCCUPATION OF DECEASED

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

Infant at Home

(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

Norman Heath

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Iowa

12. MAIDEN NAME OF MOTHER

Myrtle Tiers

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Iowa

14. INFORMANT

Norman Heath  
Springfield, Mo.

15. FILED

3/17/28 Octorst Mo  
1928

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

May 16 1928

17.

I HEREBY CERTIFY That I attended deceased from May 10, 1928 until May 16, 1928 that I last saw him alive on May 16, 1928 and that death occurred, on the date stated above, at 6 m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Malnutrition  
158/120 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 19 ds.

CONTRIBUTORY (SECONDARY)

Indigestion (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) W. B. Beyer, M. D.

(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

Willow Springs Mo Mar 27 1928

20. UNDERTAKER

ADDRESS

W. Klingner 424 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.

1928

