

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

Do not use this space.

Dr. E. E. ...
8573

1. PLACE OF DEATH

County *Greene*
Township *Springfield*
City *Springfield* (No. *1033*)

Registration District No. *318*
Primary Registration District No. *1033*

File No. *225*
Registered No. *225*
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. *1033* *Bronzeville* St., _____ Ward _____
(Usual place of abode)

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 *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) *Widow*

5A. ~~MARRIED~~, WIDOWED, OR DIVORCED HUSBAND OR (or) WIFE OF *Greene Act*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Aug 20 - 1848*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
17 *7* *3*

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. *Housewife*
(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) *Canada*

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Canada*

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Canada*

14.

INFORMANT *M. E. ...*
(Address) *1033 Bronzeville*

15.

FILED *3-28-28* 19 *28* *Oct* *for* *M. E. ...*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Mar. 23 1928*

17. I HEREBY CERTIFY That I attended deceased from *Mar. 17*, 19*28*, to *Mar. 23*, 19*28* that I last saw him alive on *Mar. 22*, 19*28*, and that death occurred, on the date stated above, at *8 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia (Croupous)

Broncho
107A (duration) yrs. mos. *7* da.
CONTRIBUTORY *Respiratory + Cardiac*
(SECONDARY) *failure* (duration) yrs. mos. *24* hours

18. WHERE WAS DISEASE CONTRACTED *107A*
IF NOT AT PLACE OF DEATH?

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? *Dr. Stollkin's* M. D.
(Signed) _____, 19 (Address) *318 College St*

*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

M. E. ... *30* 19 *28*

20. UNDERTAKER *H. E. ...*
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.

PERMANENT RECORD

1928

