

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

Do not use this space.

1. PLACE OF DEATH

County Greene

Registration District No. 318

Township

Primary Registration District No. 2001

City

Springfield (No. 500 W. Chicago)

8574

File No.

Registered No. 226

St.

Ward

2. FULL NAME

Patty Louise Stone

(a) Residence. No. 500 W. Chicago 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

F

4. COLOR OR RACE

wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED

child

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

child

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

Mar 16 - 1928

7. AGE

0

YEARS

0

MONTHS

13

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Springfield

(STATE OR COUNTRY)

10. NAME OF FATHER

F. C. Stone

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Cave Spring

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Key White

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Ash Grove

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

F. C. Stone
Springfield Mo

15.

FILED

3-29-28

1928

O. Horst

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

3/29 1928

17.

I HEREBY CERTIFY, That I attended deceased from

....., 19....., to

....., 19.....

that I last saw h..... alive on

....., 19....., and that

death occurred, on the date stated above, at

IA

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial

Pneumonia

10 IA

duration

CONTRIBUTORY

(SECONDARY)

10 IA

(duration)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

9 DID AN OPERATION PRECEDE DEATH?

DATE OF

10 WAS THERE AN AUTOPSY?

no

11 WHAT TEST CONFIRMED DIAGNOSIS?

clinical exam

(Signed)

Jewell E. Wimple

3/29/28 (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

Ash Grove Mo

3/29 1928

20. UNDERTAKER

ADDRESS

Alma Schuierer 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

428