

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

Do not use this space.

12743

1. PLACE OF DEATH
 County Dade Registration District No. 237
 Township Dade Primary Registration District No. 4144
 City Greenfield (No. _____) St. _____ Ward _____

2. FULL NAME
Montgomery, infant.
 (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 male **4. COLOR OR RACE** white **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** single
 (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 7 1928

7. AGE YEARS MONTHS DAYS 5
 If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work none
 (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) Dade Co Mo.

10. NAME OF FATHER Troy Montgomery

11. BIRTHPLACE OF FATHER (CITY OR TOWN); (STATE OR COUNTRY) Dade Co. Mo

12. MAIDEN NAME OF MOTHER Sam. Taylor

13. BIRTHPLACE OF MOTHER (CITY OR TOWN); (STATE OR COUNTRY) Monifield, Wyo. W. 87

14. INFORMANT (Address) Troy Montgomery Greenfield, Mo

15. FILED 5-7, 1928 REGISTRAR E. Ball

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 12 1928

17. I HEREBY CERTIFY, That I attended deceased from April 7 1928 to April 12 1928, that I last saw him alive on April 17 1928, and that death occurred, on the date stated above, at 2 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Septicemia - from
unsterilized cord. 1610

16 1/2 (duration) yrs. mos. ds.
CONTRIBUTORY Large Cord. Abnormal
 (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH. NO DATE OF _____

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS, _____
 (Signed) R. B. Kirby, M. D.
Apr 12 1928 (Address) Dadeville 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 Apr. 13 1928

20. UNDERTAKER G. McWard ADDRESS Greenfield Mo

N. B.—Every item of information should be carefully supplied. AGE should be given EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PRINT WITH UNFADING INK—THIS

JUL 5 1928

should be
very important

NO. 100
PROPERTY CLASSIFIED
EXCEPT WHERE SHOWN
OTHERWISE

100

**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 Dade Registration District No. 237 File No.
 Township Greenfield Primary Registration District No. 4144 Registered No. 27
 City Greenfield (No.) St. Ward)

2. FULL NAME Unnamed Montgomery
 (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 s (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 (duration) yrs. mos. ds.
 (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)
 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 7-19, 1928 E. O. Ball REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 12 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 m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
 CONTRIBUTORY (SECONDARY) (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 Bald Mound DATE OF BURIAL 19
 20. UNDERTAKER ADDRESS

SUPPLEMENTARY

STATE PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK

N. B.—Every item of information should be carefully checked and should be stated in plain terms, so that it may be properly classified. Exact certification is of great importance and is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-12-43