

MAY 31 1928

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

Do not use this space.

W. H. ...
12892

1. PLACE OF DEATH

County *Greene* Registration District No. *318*
Township *Springfield No* Primary Registration District No. *2001*
City *Springfield* (No. *1st*) St. *Spring* Ward

File No. _____
Registered No. *247*
Sl. _____ Ward

2. FULL NAME

Homer P. Maghewine
(a) Residence. No. *717 State Street* 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *March 10 - 1890*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
38 0 22

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Shopman*
(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) *Miss Mo*

PARENTS

10. NAME OF FATHER *Philip Maghewine*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) *Mo*

12. MAIDEN NAME OF MOTHER *Emma Meyer*

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

14. INFORMANT *Miss Mrs. ...* (Address) *717 State Street*

15. FILED *4/3 28* REGISTRAR *O. Horst*

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *4/2 1928*

17. I HEREBY CERTIFY, That I attended deceased from *3/24*, 1928, to *Apr. 1*, 1928 that I last saw him alive on *Apr. 1*, 1928, and that death occurred, on the date stated above, at *11 p.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia (Broncha)
90 W (duration) *107 H* + *3* da.

CONTRIBUTORY (SECONDARY) *Influenza - 2 wks. - chronic*
Heart disease (mitral) (duration) *10* yrs. mos. da.

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

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF _____

20. WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) *S. B. ...*, 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.

21. PLACE OF BURIAL, CREMATION, OR REMOVAL *Cemetery* DATE OF BURIAL *4/1 1928*

20. UNDERTAKER *H. H. Meyer* ADDRESS _____

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY.

