

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 Springfield Primary Registration District No. 907

City Springfield (No. 907) L. Newton St. 277 Ward

File No. 12922

Registered No. 277

2. FULL NAME

(a) Residence. No. 907 L. Newton St. 277 Ward. (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

3. SEX

Female

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Single

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

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

Aug 23-1925

7. AGE

YEARS 2

MONTHS 7

DAYS 18

IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

Harvey L. Wilson

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

Mo.

12. MAIDEN NAME OF MOTHER

Ruth Carroll

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

Mo.

14. INFORMANT (Address)

Harvey L. Wilson
Springfield, Mo.

15. DATES

4/11 28 Oct 1st 1928
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

4-11 1928

17. I HEREBY CERTIFY, That I attended deceased from Apr. 5, 1928, to Apr 11, 1928 that I last saw her alive on Apr 10, 1928, and that death occurred, on the date stated above, at 10 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia - Bronchus Primary
Diphsitis -
Acute hemorrhagic nephritis -
(duration) X yrs. 1 mos. — da.

CONTRIBUTORY (SECONDARY)

Cardiac failure -
(duration) X yrs. X mos. 1 da.

18. WHERE WAS DISEASE CONTRACTED

1000 at home 1078
IF NOT AT PLACE OF DEATH 12113

DID AN OPERATION PRECEDE DEATH? No. DATE OF — 180

WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS? All physical signs plus
(Signed) W. H. Burke, M. D.
, 19 (Address) 214 No. Jefferson

*State the DISEASE CAUSING DEATH, or in death 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

Green Lawn Cemetery April 12 1928

20. UNDERTAKER

W. H. Burkner & Co 424 E. 8th St
Springfield, Mo.

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

