

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

Do not use this space.

12947

1. PLACE OF DEATH Greene Registration District No. 318 File No. \_\_\_\_\_  
 County \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registered No. 306  
 Township \_\_\_\_\_ City Springfield (No. 2033) Washington St. \_\_\_\_\_ Ward \_\_\_\_\_  
 2. FULL NAME Martha Ann Twigger  
 (a) Residence. No. 2033 Washington 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. 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) Widow  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 7 - 1857  
 7. AGE YEARS MONTHS Days If LESS than 1 day, hrs. or min.  
70 7 12  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work at Home  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4 / 19 1928  
 17.  I HEREBY CERTIFY That I attended deceased from 3/20 1928 to 4/19 1928 that I last saw him alive on April 18, 1928, and that death occurred, on the date stated above, 7 p.m.  
 THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Valvular heart Lesion  
4000 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.  
 CONTRIBUTORY (SECONDARY) Influenza (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) England  
 10. NAME OF FATHER Benjamin Knowles  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) England  
 12. MAIDEN NAME OF MOTHER Unknown  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

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: Physical  
 (Signed) R. F. Hanna, M. D.  
4/20, 1928 (Address) Springfield Mo

14. INFORMANT H. Twigger  
 (Address) Springfield Mo.  
 15. FILED 4/21 1928 Octorst Mo  
 REGISTRAR \_\_\_\_\_

\*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  
Green Lawn Cemetery April 22 1928  
 20. UNDERTAKER H. Twigger Pub. Co. ADDRESS Springfield, Mo.

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

