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

Do not use this space.

File No. 16780

Registered No. 361

1. PLACE OF DEATH

County: Greene — Registration District No. 318

Township: Springfield — Primary Registration District No. 2001

City: Springfield (No. 950, W. Walnut St., Ward)

2. FULL NAME: Amanda Raffety

(a) Residence. No. 950 W. Walnut St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 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: W.

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 23 - 1885

7. AGE: Years 43 | Months 0 | Days 16 | If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Wife
(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): Ill.

PARENTS

10. NAME OF FATHER: J. Hurley

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

12. MAIDEN NAME OF MOTHER: Mathews

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

14. INFORMANT: Mrs H. E. Rockstool
(Address) 950 W. Walnut St.

15. FILED 5-10, 1928 O. C. Horst M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 9 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 4 pm.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Intestinal Obstruction
122B
162
(duration) ...yrs. ...mos. 17 ds.

CONTRIBUTORY (SECONDARY): Senility
(duration) ...yrs. ...mos. ...ds.

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

O DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) C. T. Feller, M. D.

5-10-, 1928 (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: Mount Sum Cemetery — DATE OF BURIAL: 5-11 1928

20. UNDERTAKER: W. L. Stone — ADDRESS: Walnut & Market

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A F[illegible]RTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH
County Greene — Registration District No. 318 — File No.
Township — Primary Registration District No. 2002 — Registered No. 361
City Springfield (No. ..... St. ..... Ward)

2. FULL NAME Amanda Raffety
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	W	Wid

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
(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)

PARENTS
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 5-10, 1928 O. C. Horst Mrs. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 9 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:
Intestinal Obstruction
Cause unknown
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) Senility
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? ..... DATE OF 1932
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	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY