

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

Do not use this space.

Dr. Ellis
16782

1. PLACE OF DEATH

County Greene Registration District No. 318
Township Springfield mo Primary Registration District No. 1001
City Springfield (No.) St. Ward)

File No.
Registered No. 363
St. Ward)

2. FULL NAME

(a) Residence. No. 1604 20th 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

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 11 1928

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

17. I HEREBY CERTIFY That I attended deceased from May 9, 1928, to May 9, 1928, that I last saw him alive on May 9, 1928, and that death occurred, on the date stated above, at 8:45 a.m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 29, 1842

THE CAUSE OF DEATH WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 85 80 12

Acute Marasmus
84
162.97 (duration) yrs. mos. da. 6
CONTRIBUTORY (SECONDARY) Exhaustion, weak heart (duration) yrs. mos. da.

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Plumber (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

18. WHERE WAS DISEASE CONTRACTED

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ohio

IF NOT AT PLACE OF DEATH.....
DATE OF OPERATION PRECEDE DEATH..... DATE OF.....

10. NAME OF FATHER David V. Baser

WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS? Cholera (Signed) Dr. Ellis, M. D.

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

, 19 (Address) 318 College

12. MAIDEN NAME OF MOTHER Elizabeth Baser

*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.

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

14. INFORMANT (Address) Dr. Ellis

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL Springfield, Mo. 20

15. FILE NO. 5-11-28 Registrar W. H. Baser

20. UNDERTAKER ADDRESS Springfield, MO.

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

THIS IS PERMANENT RECORD

