

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

Do not use this space.

20375

1. PLACE OF DEATH

County Greene

Registration District No. 318

Township Springfield

Primary Registration District No. 2001

City Springfield

File No. _____

Registered No. 422

St. _____ Ward _____

2. FULL NAME

(a) Residence No. 2123 Johnson 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

Male

4. COLOR OR RACE

White

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

Widower

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

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

Jan 24 - 1852

7. AGE

YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
76 | 4 | 8

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer
(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) Ark

10. NAME OF FATHER

Robert Fallin

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Tenn.

12. MAIDEN NAME OF MOTHER

Nancy Cabell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Tenn.

14.

INFORMANT

(Address) J. W. Fallin Springfield, Mo.

15.

FILE

6-4-28 W. O. Foster Mo. REGISTERAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 2 19 28

17. I HEREBY CERTIFY, That I attended deceased from _____
Apr 19 25, to June 2 19 28
that I last saw h. alive on June 2 19 28, and that death occurred, on the date stated above, at 12:30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

93c Chronic Myocarditis

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) C. E. Fulton M. D.

, 19 (Address) Rte 3 Springfield Mo

*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

Northfort Cemetery June 4 19 28

20. UNDERTAKER

ADDRESS

Willingham 424 E Paul St
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.

