

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

File No. 20385

Township Springfield

Primary Registration District No. 2001

Registered No. 434

City Springfield (No. 1616 Ozark Ave)

St. _____ Ward _____

2. FULL NAME Erva Brees

(a) Residence. No. 1616 Ozark Ave 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. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 8 1928

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

17. I HEREBY CERTIFY That I attended deceased from June 7 1928 to June 8 1928 that I last saw him alive on June 8 1928, and that death occurred, on the date stated above, at 4:30 m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 6 - 1905

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS Days If LESS than 1 day, ____ hrs. or ____ min. 22 11 2

23A Pleuro Pneumonia
(duration) _____ yrs. _____ mos. _____ ds.

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 _____

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

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

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

10. NAME OF FATHER Erwin Brees

1) DID AN OPERATION PRECEDE DEATH? No DATE OF _____

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

2) WAS THERE AN AUTOPSY? No

12. MAIDEN NAME OF MOTHER Charma Adkins

WHAT TEST CONFIRMED DIAGNOSIS? Pleuro pneumonia
(Signed) J. O. Sawyer M. D.

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

(Address) 623 W. 4th St.

14. INFORMANT L. P. Brees (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.

15. FILED 6-9-28 19. Oct 1928 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL Timber Ridge cemetery June 9 1928

20. UNDERTAKER L. W. Klingner & Co. 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.

Section of Inform
5 ON DEATH in plain

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... may be properly classified. Exact statement of OCCURREN...

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Greene

Registration District No. 318

File No.

Township

Primary Registration District No. 2002

Registered No. 434

City Springfield (No.)

St. Ward)

2. FULL NAME

Ewa Brees

(a) Residence. No. 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. 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 S (write the word)

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)

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. 6-9-28 Octford Miss REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 8 1928

17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19..... that I last saw him alive on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Abscess Pleura
Probably Tuberculous
No accident

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

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

20. UNDERTAKER

ADDRESS

PHYSICIANS should state OCCUPATION is very important.
 NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
 K. B.— CAUSE REGIST
 Information should be carefully stated in plain terms, so that it may be placed in simple English.
 X. B.— CAUSE REGIST

SUPPLEMENTARY

S-20385