JUL 25 1928

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

Do not use this space.
Fulbright
20413

File No. .....
Registered No. 470

1. PLACE OF DEATH
County Greene
Registration District No. 318
Township ....
Primary Registration District No. 2001
City Springfield (No. St. Johns Hosp. St. Ward)

2. FULL NAME Fannie L. Hughes
(a) Residence. No. 1929 College 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 Female
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED, (write the word) Married

5a. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF Walter L. Hughes

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 21-1878

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
50	3	5	

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) Mo.
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Lewis Marsh
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown

14. INFORMANT W. L. Hughes
(Address) Springfield. Mo.

15. Filed 6-27, 1928 O. C. Horst M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

1

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 26 1928

17. I HEREBY CERTIFY, That I attended deceased from 6/12, 1928, to 6/26, 1928, that I last saw h. alive on 6/26, 1928, and that death occurred, on the date stated above, at 9 ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Nephritis
130
15 (duration) ..... yrs. ..... mos. ..... ds.

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

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH? .....
0 DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Examination & Urine
(Signed) J. H. Fulbright, M. D.
June 29, 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 Green Lawn Cemetery — DATE OF BURIAL June 28 1928

20. UNDERTAKER F. W. Klingner Co. — ADDRESS 426 E. Court 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.

PHYSICIAN'S STATEMENT OF DEATH IS A PERMANENT RECORD

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. 2001 — Registered No. 470

City Springfield (No. ..... St. ..... Ward)

2. FULL NAME Fannie L. Hughes

(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 (*write* the word) M

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)
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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 6-27, 1928 OC Horst
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Nephritis
Cause unknown
..... (duration) ..... yrs. ..... mos. ..... ds.

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 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

REGISTRAR SHALL NOT RECEIVE A ... OR CERTIFICA... TIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
... of information s... fully supplied ... should be stated EXACTLY. PH... S... ...te
... in plain terms, ... may be prope... Exact statement of OCCUPATION ... very important.

S-20413