

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

Do not use this space.

23530

1. PLACE OF DEATH

County Greene Registration District No. 318
Township _____ Primary Registration District No. 2001
City Springfield (No. 752 S Missouri) St. _____ Ward _____

File No. _____
Registered No. 558

2. FULL NAME

(a) Residence, No. 752 S Missouri 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 m 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 21-1851

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 77 6 10

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retd
(b) General nature of industry, business, or establishment in which employed (or employer) Missionary
(c) Name of employer _____

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

10. NAME OF FATHER Phillip Essex

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

12. MAIDEN NAME OF MOTHER Mary Burgess

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

14. INFORMANT (Address) Mrs. Holland Bennett Springfield Mo

15. Filed 8/21/28 1928 OC Forrest REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-31-28

17. I HEREBY CERTIFY That I attended deceased from July 10, 1928, to July 31, 1928 that I last saw him alive on July 31, 1928 and that death occurred, on the date stated above, at 11:39 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Paralysis
and
stroke
(duration) _____ yrs. _____ mos. _____ ds.

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH Ashe Grove Mo

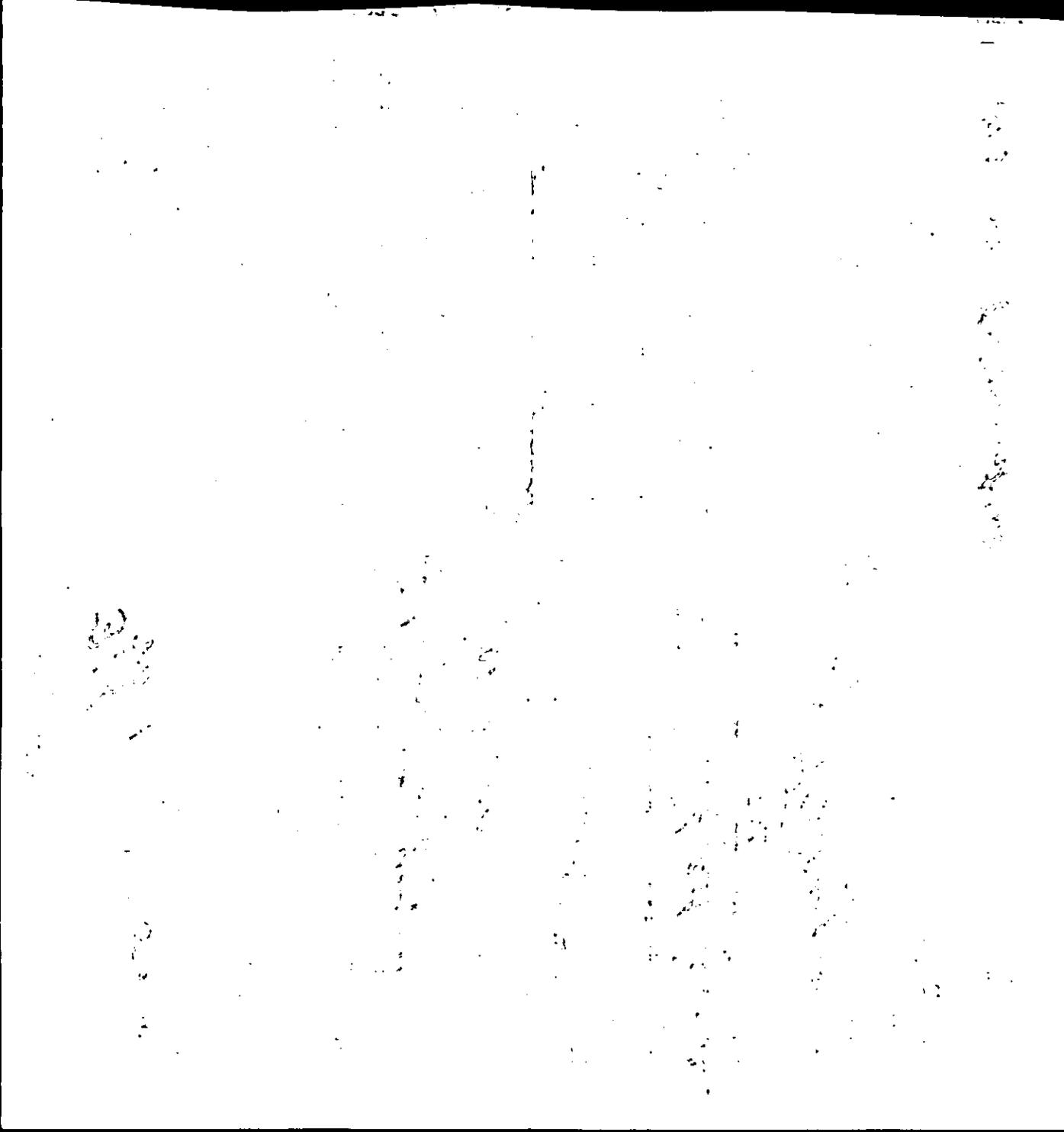
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS (Signed) D. F. Neuman M. D.
28 (Address) Springfield Mo

*State the DISEASE CAUSING DEATH, or if 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 Ashe Grove Mo DATE OF BURIAL 8-2-28

20. UNDERTAKER Alma Schmeyer ADDRESS 534 1/2 Lane



**MISSOURI STATE BOARD OF HEALTH
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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. 0-5-5-
 City Springfield (No. _____) St. _____ Ward _____

2. FULL NAME

(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 m 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) _____
 (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. FILED 8/28 October 1928 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-31-28

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:

Paralysis following
stroke hemiplegia
(apoplexy) (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

THIS FORM SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AND APPROVED BY LAW

S-23530

1947
1/11/47