

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

AUG 23 1928

1. PLACE OF DEATH

County GreeneRegistration District No. 318

Township

Primary Registration District No. 2001

City

Springfield (No. Baptist Hospital)File No. 23535Registered No. 511

St.

Ward)

2. FULL NAME

(a) Residence. No. Rd 3

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

wh

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

child

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

child

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

Dec 30 - 1926

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, _____ hrs. or _____ min.

1612

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

child

(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)

Springfield Mo

10. NAME OF FATHER

Ed Thompson

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

Mo

12. MAIDEN NAME OF MOTHER

Jagelle Holloway

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

Kans

14.

INFORMANT (Address)

Ed Thompson Springfield Mo

15.

7-13/28 Oct 1st 1928

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

7-12 1928

17.

I HEREBY CERTIFY That I attended deceased from 7:30 P.M. July 11, 1928, to 7:00 A.M. July 12, 1928 that I last saw him alive on July 12, 1928 and that death occurred, on the date stated above, at 7:00 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Phosphorus Poisoning from eating fireworks. (Accidental)Pulmonary edema and Myocardial degeneration

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

Home

DID AN OPERATION PRECEDE DEATH?.....

no DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS breath - urine -
(Signed) W.H. Burkley, M.D.
, 19 (Address) 1214 7th Jefferson

*State the DISEASE CAUSING DEATH, or in deaths from ACCIDENTAL 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

Hazelwood Cem7-14 1928

20. UNDERTAKER

ADDRESS

Clara Schreyer 534 Stans

RECORD WITH CONTINUING INK--THIS IS A PERMANENT RECORD

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.

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