

AUG 23 1928

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

Do not use this space.

1. PLACE OF DEATH

County S Greene

Registration District No. 318

File No. 23549

Township Springfield

Primary Registration District No. 2001

Registered No. 525

City Springfield (No.)

St. Ward

2. FULL NAME

(a) Residence. No. 820 South Ave 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 Female

4. COLOR OR RACE White

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 3-1896

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 32 5 12

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) Texas

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT (Address) Mrs. M. Gray Springfield Mo

15. FILED 7-18-28 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 15 1928

17. I HEREBY CERTIFY That I attended deceased from July 10 1928 to July 15 1928 that I last saw him alive on July 15 1928, and that death occurred, on the date stated above, at 130 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumococci meningitis

(duration) 3 yrs. mos. da.

CONTRIBUTORY (SECONDARY) Pneumonia

(duration) probably 10 yrs. mos. da.

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

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

19. WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS Bacteriology

(Signed) J. J. Hayes

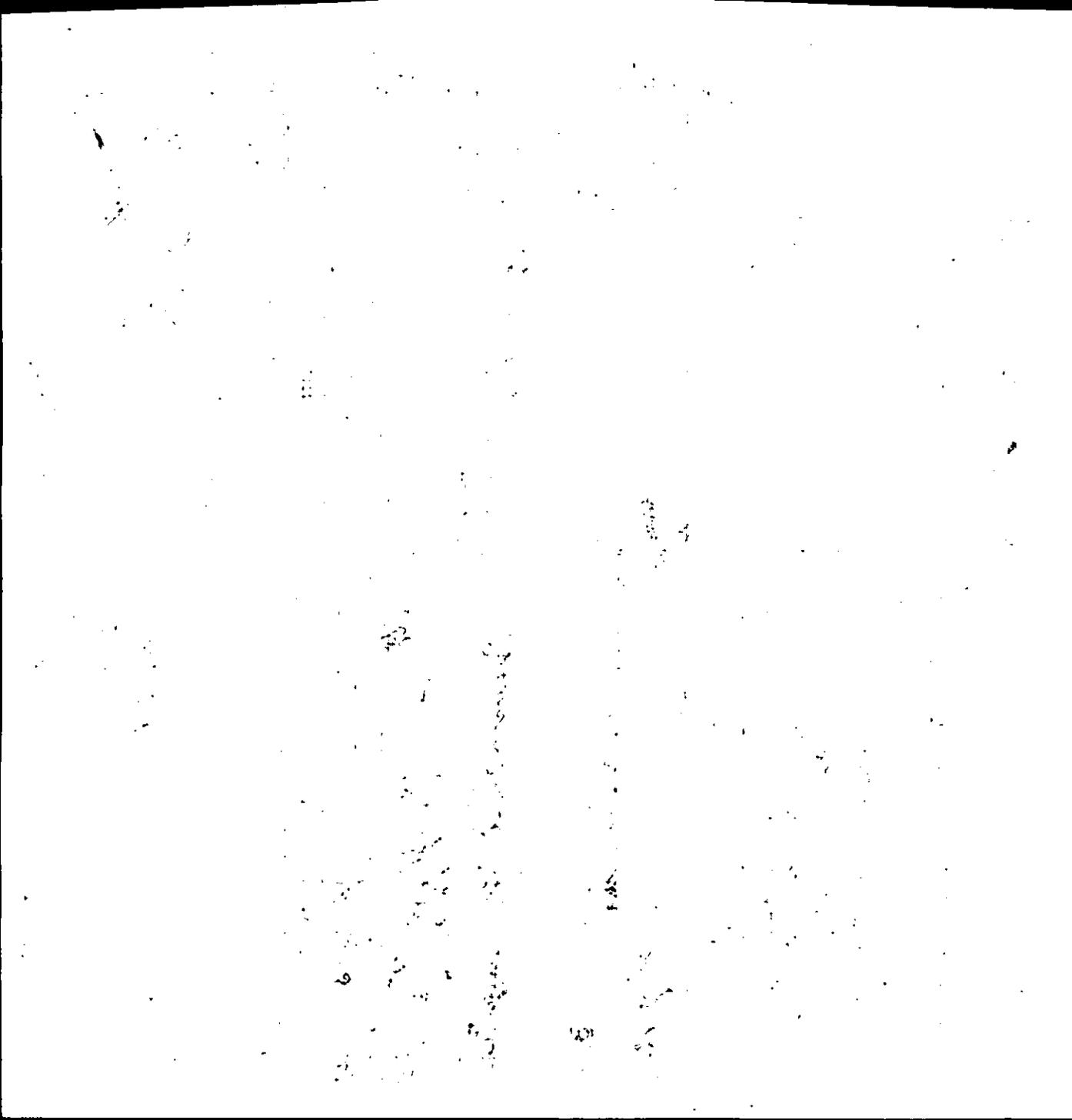
, 19 (Address) 622 Woodway

*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 Maple Hill DATE OF BURIAL July 18 1928

20. UNDERTAKER W. J. Schumper ADDRESS

SPRINGFIELD, MO.



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

ALL INFORMATION REQUESTED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Gilmer Registration District No. 318 File No. _____
 Township _____ Primary Registration District No. 2001 Registered No. 323-
 City Springfield (No. _____) St. _____ Ward _____

2. FULL NAME Mrs Mable Gray

(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) X

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) _____

Filed 7-18-28 October 1928 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 15 - 1928

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, (that I last saw h. _____ since on _____, 19____, and that death occurred, on the date stated above, at _____, Mo.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumococci meningitis
 _____ (duration) _____ yrs. _____ mos. _____ ds. X
 CONTRIBUTORY (SECONDARY) Pneumonia
Bronchitis (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? DATE _____
 WAS THERE AN AUTOPSY? 1000
 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 _____
 ADDRESS _____ 19____
 UNDERTAKER _____

SUPPLEMENTARY

REGISTRATION SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-23549