

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 Greene Registration District No. 318
Township Springfield Mo Primary Registration District No. St John Hospital
City Springfield Mo (No. St John Hospital) Ward)

Dr Sample
File No. 23555
Registered No. 532

2. FULL NAME

(a) Residence. No. 1278 E. market St., Ward. St John Hospital
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U.S. of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown 1908

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
20 Unknown

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER Fred. Mergel

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 Beccar, Stoneyer
(Address) Springfield Mo

15. FILED 7-20-28 October 1928 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/19 1928

17. I HEREBY CERTIFY, That I attended deceased from July 18, 1928, to July 19, 1928, that I last saw him alive on July 19, 1928, and that death occurred, on the date stated above, at 3:30 pm m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Concussion and laceration of brain
(duration) yrs. mos. 2 da.

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

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

DID AN OPERATION PRECEDE DEATH? No DATE OF -

WAS THERE AN AUTOPSY? No

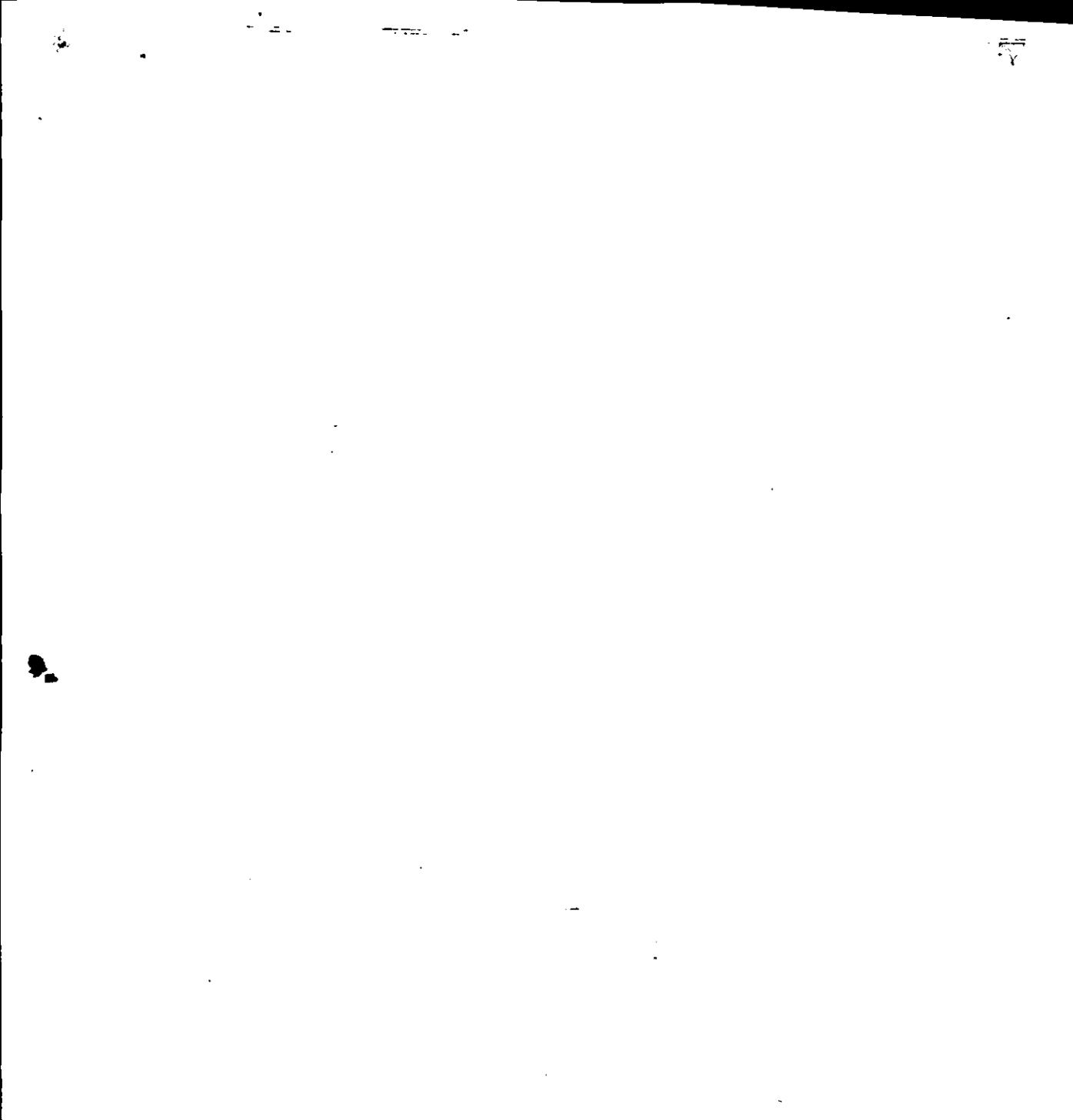
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) F. J. St. Louis, M. D.
, 19 (Address) 401 St Louis

*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 St. John Hospital DATE OF BURIAL July 23 1928

20. UNDERTAKER H. H. Mergel ADDRESS Springfield Mo

PARENTS



**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
Township _____
City Springfield

Registration District No. 318
Primary Registration District No. 2001

File No. _____
Registered No. 332
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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 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.

FILED

7-20-28 October

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-19-28

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:

Concussion and laceration of brain
Automobile Accident
from car

CONTRIBUTORY (SECONDARY) _____

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

NOT RECEIVE A FEE FOR CERTIFICATES UNTIL TH ARE COMPLETED BY LAW

S-23555