

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

Do not use this space.

26988

1. PLACE OF DEATH Home Registration District No. 318
 County Greene File No. _____
 Township Springfield Primary Registration District No. 2001 Registered No. 557
 City Springfield (Ward) _____
 2. FULL NAME Infant son of Mr & Mrs Zack Christian
 (a) Residence. No. 2409 W State St 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 (circle the word) Infant
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE of

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug-1-1928

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ___ hrs. or ___ min.
0 0 2

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Infant
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Missouri
 (STATE OR COUNTRY)

10. NAME OF FATHER Zack Christian

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

12. MAIDEN NAME OF MOTHER Madge Hogeman

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

14. INFORMANT Zack Christian
 (Address) 2409 W State St

15. FILE NO. 8-4-28 Ob Horat Mo
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug-3 1928
 17. _____

I HEREBY CERTIFY That I attended deceased from Aug 1, 1928, to Aug 3, 1928, that I last saw er alive on Aug 3, 1928, and that death occurred, on the date stated above, at _____

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1516 Asphyxia livida
1610

(duration) yrs. mos. 2 da.

CONTRIBUTORY Irregular heart
 (SECONDARY)

(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED 15410
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? clinical

(Signed) Arthur D. Krabb, M. D.

8-4, 1928 (Address) 450 1/2 E. Commercial

*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. Always Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Greene's Ridge DATE OF BURIAL 8/5 28

20. UNDERTAKER W. K. King ADDRESS Springfield Mo

WRITE PLAINLY, WITH UNFADING 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.

1928

