

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

Do not use this space.

Dr. *Shelley* 230230
File No. _____
Registered No. *6605*
St. _____ Ward)

1. PLACE OF DEATH

County *Chester*
Township _____
City *Springfield Mo*

Registration District No. *318*
Primary Registration District No. *2001*

2. FULL NAME

(s) Residence. No. *1335 No. Linden* Ward. _____
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Divorced*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Unknown 1907*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *21 Unknown*

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work *Teacher* (b) General nature of industry, business, or establishment in which employed (or employer) *1357 1357* (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

10. NAME OF FATHER *John Brown*

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

12. MAIDEN NAME OF MOTHER *Theresa O'Leary*

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

14. INFORMANT (Address) *Mrs. Theresa Brown 1335 No. Linden Springfield Mo*

15. FILED *24 1928* REGISTRAR *O. Horst M.*

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 22 1928*

I HEREBY CERTIFY, That I attended deceased from *Sept 19 1928*, to *Sept 22 1928*, that I last saw her alive on *Sept 22 1928*, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute myocarditis
8815
CONTRIBUTORY (SECONDARY) *Turulent Cystitis* (duration) yrs. mos. ds. *3*
(duration) yrs. mos. ds. *2*

18. WHERE WAS DISEASE CONTRACTED *At place of death*
IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF *Sept 12*

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMS DIAGNOSIS? *General Symptoms*
(Signed) *D. H. Sherman* M. D.
, 19 (Address) *Springfield Mo*

*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 (Address) *Springfield Mo* DATE OF BURIAL *9/24 1928*

20. UNDERTAKER (Address) *Springfield Mo*

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.

DEATH RECORD

