

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

Do not use this space.

30247

**1. PLACE OF DEATH**

County Greene

Registration District No. 318

Township Springfield

Primary Registration District No. 2001

City Springfield (No. 801 N. Warren)

File No. 6844

Registered No. 6844

St. Mo. Ward

**2. FULL NAME**

(a) Residence. No. 801 Warren St., Mo. 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 Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 5 - 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
69 7 12

**8. OCCUPATION OF DECEASED**

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

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

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

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Mrs. Lizzie Stokes  
(Address) Springfield, Mo.

15. FILED 9/19/28 REGISTRAR O. H. Foster

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-17 1928

17. I HEREBY CERTIFY, That I attended deceased from 9-10, 1928 to 9-17, 1928, that I last saw him alive on 9-10, 1928, and that death occurred, on the date stated above, at 10:00 a.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Suprarenal abcess.  
5 1/2  
15 1/2  
11 1/2 (duration) yrs. 6 mos. 0 ds.

CONTRIBUTORY (SECONDARY) Essentially  
(duration) yrs. mos. ds.

**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) A. P. Zeller, M. D.

9-17, 1928 (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 Kerr Cemetery DATE OF BURIAL Sept 19 - 1928

20. UNDERTAKER J. W. Klingner & Co., Springfield  
ADDRESS 42

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



**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

Registration District No. 318

File No. \_\_\_\_\_

Township \_\_\_\_\_

Primary Registration District No. 2001

Registered No. 684

City Springfield (No. \_\_\_\_\_)

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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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 9/19/28 Lon Sharp REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 17 19 28

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Suppurative abscess  
Not traumatic Not tubercular  
probably following malignancy  
of unknown (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Senility yrs. mos. ds.

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 \_\_\_\_\_

**SUPPLEMENTARY**

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

could not be stated EXACTLY in plain terms, so that it may be properly

ADMINISTRATIVE

ADVIS

PI

S-30247