

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

Do not use this space.

**1. PLACE OF DEATH**

County Greene  
Township Springfield  
City Springfield

Registration District No. 318  
Primary Registration District No. 20-01

File No. 33280  
Registered No. 709  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence No. 927 N. Division St. \_\_\_\_\_ 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.

**PERSONAL AND STATISTICAL PARTICULARS**

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

Female      white      Married

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

Lawrence D. McCloskey

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

Nov 30, 1887

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

40      10      9

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work House Wife  
(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)**

Marshfield Mo

**10. NAME OF FATHER**

Price Robinson

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

Mo.

**12. MAIDEN NAME OF MOTHER**

Mattie Jernigan

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

Mo.

**14.**

INFORMANT (Address) Lawrence D. McCloskey Springfield, Mo.

**15.**

FILED 10-16-28 19 28 Oct 10 1928

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** 10-9-1928

**17. I HEREBY CERTIFY** That I attended deceased from any 13 1927 to Oct 9 1928  
and that I last saw him alive on Oct 9 1928, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

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

Cancer of Uterus  
4 1/2 (duration) 1 yrs. 6 mos. ds.  
CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH \_\_\_\_\_

**DID AN OPERATION PRECEDE DEATH?** Yes DATE OF Aug 17-1928  
**WAS THERE AN AUTOPSY?** No

**WHAT TEST CONFIRMED DIAGNOSIS?** clinical & Lab.  
(Signed) W. L. Edmerrdson, M. D.  
(Address) 318 1/2 College St. W.

\*State the DISEASE CAUSING DEATH, or in death 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**

Green Lawn cemetery      Oct 11 1928

**UNDERTAKER** E. W. Klingner      **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.

21 1928

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