

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

Do not use this space.

7099
33288

1. PLACE OF DEATH

County Greene Registration District No. 318
Township Springfield Primary Registration District No. 2001
City Springfield (No. 565 St Louis St) St. _____ Ward _____

File No. _____
Registered No. 718 St. _____ Ward _____

2. FULL NAME

Florine Bigbee
(a) Residence No. 365 St Louis 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 F 4. COLOR OR RACE Wh. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND-OR (OR) WIFE OF Mrs J. Bigbee

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 7-1853

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
75 5 1

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

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

10. NAME OF FATHER Thos. B. Townsend

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

12. MAIDEN NAME OF MOTHER Elizabeth Under

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

14. INFORMANT Mrs. Mrs J. Bigbee
(Address) Springfield Mo.

15. FILED 10-15-28 Oct Forest Mo
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-8 1928

17. I HEREBY CERTIFY, That I attended deceased from Oct 4, 1928, to Oct 11, 1928 that I last saw him alive on Oct 11, 1928, and that death occurred, on the date stated above, at 12 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heart Disease (Hypertensive or arteriosclerotic type) of 912
Myocarditis (duration) 1 yrs. 5 mos. 5 ds.

CONTRIBUTORY (SECONDARY) _____

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

DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) Chas. Callaway M. D.
, 19 28 (Address) Springfield Mo

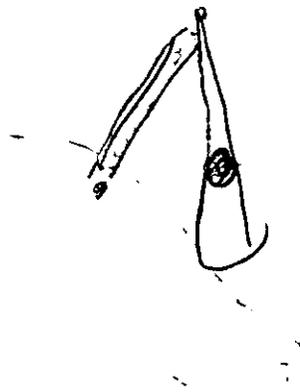
*State the DISEASE CAUSING DEATH, or in cases from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Maple Park DATE OF BURIAL 10-9 1928

20. UNDERTAKER Elma Schreyer ADDRESS 534 St Louis

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

K. 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.



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