

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

Do not use this space.

1 1928

**1. PLACE OF DEATH**

County Greene Registration District No. 318 File No. 33299  
 Township Springfield Primary Registration District No. 2001 Registered No. 73V  
 City Springfield (In) 1921 Taylor AVE. St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. 1921 Taylor 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 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 Caroline Gottas

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 29-1866

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
62 | 8 | 19 | \_\_\_\_\_

8. OCCUPATION OF DECEASED Plumber  
 (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) Ohio  
 (STATE OR COUNTRY)

10. NAME OF FATHER John Gottas

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT John J. Gottas  
 (Address) Springfield, Mo.

15. FILED 10-18-28 19. October REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/18 1928

17. I HEREBY CERTIFY That I attended deceased from 10/15, 1928, to 10/18, 1928 that I last saw him alive on 10/18, 1928, and that death occurred, on the date stated above, at 10:30 a.m.

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

exceptive Brain Tumor  
Kind unknown  
 (duration) 7 yrs. 1 mo. \_\_\_\_\_ da. \_\_\_\_\_

CONTRIBUTORY (SECONDARY) Paralysis  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mo. 3 da. \_\_\_\_\_

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH: \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Cerebral  
 (Signed) D. J. Freeman, M. D.

10/18, 1928 (Address) Springfield

\*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 Green Lawn Cemetery DATE OF BURIAL Oct 19, 1928

20. UNDERTAKER J. W. Kingman & Co. 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.

WRITE IN INK, WITH UNFADING INK—THIS IS A PERMANENT RECORD

... But every item of information should be carefully checked. AGH should be  
CAUTION ON DATA in plain terms, so that it may be properly classified. Ex-

**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. 732  
 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 <u>M</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>M</u>
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		
PARENTS	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 <u>10/18/28</u> <u>Oct 18</u> 19 <u>28</u> REGISTRAR		

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-18-28

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_ that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, of \_\_\_\_\_.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Encephalitis - Brain  
unknown kind unknown

CONTRIBUTORY (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
paralysis  
 SECONDARY (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
unknown

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
20. UNDERTAKER	ADDRESS

**SUPPLEMENTARY**

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state by classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-33099