

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

Do not use this space.

1929

40267

1. PLACE OF DEATH

County *Greene*

Registration District No. *318*

File No.

Township *Springfield*

Primary Registration District No. *2001*

Registered No. *876*

City *Springfield*

No. *947 N. Broadway*

St.

Ward

2. FULL NAME

(a) Residence. No. *947 N. Broadway*

(Usual place of abode)

Ward.

(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 MEDICAL CERTIFICATE OF DEATH

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 Wilkerson*

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

*Sept 18-1850*

7. AGE

YEARS *78*

MONTHS *2*

DAYS *29*

IF LESS than 1 day, *hrs.* or *min.*

8. OCCUPATION OF DECEASED

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

*Carpenter*

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

*Ky*

(STATE OR COUNTRY)

10. NAME OF FATHER

*Ely Wilkerson*

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

(Address)

*Mary Wilkerson  
Springfield Mo.*

15.

FILED

*12/18/28 O. C. Horst M.D.  
REGISTRAR*

3

16. DATE OF DEATH (MONTH, DAY AND YEAR)

*12-17 1928*

17.

I HEREBY CERTIFY That I attended deceased from *12-13*, 19*28*, to *12-17*, 19*28* that I last saw *him* alive on *12-15*, 19*28*, and that death occurred, on the date stated above, at *11:30 A.M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Influenza Pneumonia*

*11A*

*109A*

*162*

CONTRIBUTORY (SECONDARY)

*Senility*

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

8

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

*P. C. Zeller*

M. D.

*19-17, 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

DATE OF BURIAL

*Green Lawn Cemetery Dec 17 1928*

20. UNDERTAKER

*J. W. Mungner 1042  
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.

