

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

Do not use this space.

1170

1. PLACE OF DEATH

County Greene Registration District No. 318
Township Springfield Primary Registration District No. R 54 39
City Springfield (No. R # 2) St. _____ Ward)

File No. _____
Registered No. 3
St. _____ Ward)

2. FULL NAME

(a) Residence. No. _____ St. _____ Word. _____
(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 Female 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 J. M. Meltabarger

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 26 - 1885

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
45 8 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

PARENTS

10. NAME OF FATHER Bill Henson

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

12. MAIDEN NAME OF MOTHER Fannie Opeland

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

14. INFORMANT J. M. Meltabarger
(Address) Springfield Mo. R # 2

15. FILED 1-2-29 O. C. Horst REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 1 - 19 29

17. I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1928, to Jan 1, 1929
that I last saw h. sa alive on Jan 1, 1928, and that death occurred, on the date stated above, at _____ ca.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

25 A Influenza
11 A
(duration) yrs. mos. ds. 2 ds.

CONTRIBUTORY Pulmonary Tuberculosis
(SECONDARY) (duration) yrs. mos. ds. 6 mos. ds.

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? Clinical
(Signed) Arthur O. Webb, M. D.

(Address) 450 1/2 E. Conil St

*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 East Lawn Cemetery DATE OF BURIAL Jan 3 1929

20. UNDERTAKER J. M. Kingrey + 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.

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