

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

Do not use this space.  
*Wilson Smith*  
6147  
File No. ....  
Registered No. *148* (Ward)

1. PLACE OF DEATH  
County *Greene* Registration District No. *318*  
Township *Springfield* Precinct Registration District No. *5439*  
City *Springfield* (No. ~~100~~) St. *Ward*

2. FULL NAME *Walter Franklin McConnell*  
(a) Residence No. *Springfield Mo. R.H. 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.

MAI 22 1929

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec 14-1919*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>10</i>	<i>1</i>	<i>28</i>	

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work *In School*  
(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) *Okla.*

10. NAME OF FATHER *Lawrence E. McConnell*

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

12. MAIDEN NAME OF MOTHER *Bessie Hogard*

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

14. INFORMANT (Address) *Mrs. Daisy Burks Springfield, Mo.*

15. FILED *2-13-29* *Ch. Forest McE* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

2  
16. DATE OF DEATH (MONTH, DAY AND YEAR) *2-12-1929*  
17. I HEREBY CERTIFY, That I attended deceased from *she* *19* to *19* that I last saw her *live on* *19* and that death occurred on the *12* day of *Feb* 19*29* at *Springfield, Mo.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS: *3 4 5 8 m*  
*Septic meningitis*  
*middle ear infection*  
CONTRIBUTORY (SECONDARY) (duration) *1* mo. *1* ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH: *no*  
DID AN OPERATION PRECEDE DEATH: *no* DATE OF *—*  
WAS THERE AN AUTOPSY: *no*  
WHAT TEST CONFIRMED DIAGNOSIS? *Histology*  
(Signed) *William Smith*, M. D.  
(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 *Bellview Cemetery* DATE OF BURIAL *2-15-29*

20. UNDERTAKER (Address) *J.W. Klingner & Co. Springfield, Mo.*

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.

WHITE PRINTING, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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