

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

Do not use this space.

6149

MAR 22 1929

1. PLACE OF DEATH

County Greene
Township Springfield
City Springfield (No. 2197)

Registration District No. 318
Primary Registration District No. 2001
State Missouri

File No. _____
Registered No. 149
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 2197 Missouri 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

MEDICAL CERTIFICATE OF DEATH

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)

July 1 - 1928

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

0

7

14

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)

(STATE OR COUNTRY)

Mo.

10. NAME OF FATHER

Wm Swaltney

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

12. MAIDEN NAME OF MOTHER

Jane McWilliam

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo

14. INFORMANT

(Address)

Wm M Swaltney
Springfield, Mo

15. FILED

FILED

2/13 29
W C Foster M.D.
REGISTRAR

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

2/13/29

17.

I HEREBY CERTIFY, That I attended deceased from 2-12-29, 1929, to 2-13-29, 1929, that I last saw him alive on 2-12-29, 1929, and that death occurred, on the date stated above, at 7 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumo pneumonia
10779

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) H B Baker, M. D.

2-13-29
2197 Missouri

*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

Wright Cemetery, Stone Co. Feb 14 1929

20. UNDERTAKER

ADDRESS

Wolkinguer & Co
124 E. Court
Springfield, Mo

GRADE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
 DEPARTMENT 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. _____
 Townshp. _____ City Registration District No. 2101 Registered No. 149
 City _____ (N. _____) St. _____ Ward _____

2. FULL NAME

Charles Kenneth Guattney
 (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

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

16. DATE OF DEATH (MONTH, DAY AND YEAR) FEB 13 1929

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

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

Progressive pneumonia
measles or Whooping Cough
 CONTRIBUTORY (SECONDARY) none (duration) _____ yrs. _____ mos. _____ ds.

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 _____

18. WHERE WAS DISEASE CONTRACTED 1000

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

PARENTS
 10. NAME OF FATHER _____
 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) _____

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) _____

14. INFORMANT _____ (Address) _____

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

15. FILED 2/13, 1929 Lon Sharp REGISTRAR

20. UNDERTAKER _____ ADDRESS _____

CAUSE OF DEATH in plain terms, so that it may be properly classified. No development of OCCUPATION is very important. REGISTRAR SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

65719-5



HEALTH

DATA

RECORDS

SECTION

OFFICE OF THE

COMMISSIONER

OF HEALTH

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