

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

Do not use this space.
6160
Hergus

1. PLACE OF DEATH

County *Greene* Registration District No. *318*
Township *Springfield* Primary Registration District No. *2001*
City *Springfield* (No. *1425 E. Madison*)

File No. _____
Registered No. *163* St. _____ Ward)

2. FULL NAME

(a) Residence No. *1425 E. Madison* (Usual place of abode) Ward. _____
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. (if nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *F* 4. COLOR OR RACE *wh* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Wed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (or) WIFE of *John H. Mills*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 13 - 1852*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
76 9 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *None*
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) *Adas* (STATE OR COUNTRY) *Ohio*

10. NAME OF FATHER *Unknown Perry*

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 *J. J. Mills* (Address) *Springfield Mo.*

15. FILED *2-20-29* *J. P. Horst* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3
16. DATE OF DEATH (MONTH, DAY AND YEAR) *2-19-29*
17. I HEREBY CERTIFY That I attended deceased from *Jan 11* 19 *29* that I last saw him alive on *July 18* 19 *29*, and that death occurred, on the date stated above, at *12:14* m.

THE CAUSE OF DEATH* was AS FOLLOWS:
Broncho pneumonia

CONTRIBUTORY (SECONDARY) *Senility myocarditis* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? _____

19. DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____ WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical* (Signed) *J. J. Horst* M. D.

*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* DATE OF BURIAL *2-21-29*

20. UNDERTAKER *Alma Schmeyer* ADDRESS *534 S. Main*

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD
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.
MAR 22 1929

