

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

Do not use this space.
DV. Thomas

6164

1. PLACE OF DEATH

County *Greene* Registration District No. *318* File No. _____
Township *Springfield* Primary Registration District No. *2001* Registered No. *167*
City *Springfield* (No. *Large Hospital*) St. _____ Ward _____

2. FULL NAME

(a) Residence No. *R# 10* 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

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) *9-3-1907*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
21 5 17

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *210M Grocery Store 918*
(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)

10. NAME OF FATHER *J. M. White*

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

12. MAIDEN NAME OF MOTHER *Esther May Pamplin*

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

14. INFORMANT *J. M. White*
(Address) *Springfield Mo. R#10*

15. FILED *Dr. O. C. Horst MD* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Feb 20 1929*

17. I HEREBY CERTIFY, That I attended deceased from *Feb 11 1929* to *Feb 20 1929*
that I last saw him alive on *Feb 20 1929*, and that death occurred, on the date stated above, at *10:45 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Endocarditis
secondary acute accident with fracture of femur and numerous internal injuries at Springfield Mo. (duration) yrs. - mos. 10 ds.

CONTRIBUTORY (SECONDARY) *Greene County*
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *Mo*
IF NOT AT PLACE OF DEATH, _____

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

WHAT TEST CONFIRMED DIAGNOSIS? *St. Thomas*
(Signed) _____ M. D.
2/21, 1929 (Address) 614 Sanders Bldg

*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 *Witch Cemetery Co.* DATE OF BURIAL *Feb 22 1929*

20. UNDERTAKER *J. W. Klingner & 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.

MAR 22 1929

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