

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

Do not use this space.

*W 7 6171
Fuller*

1. PLACE OF DEATH

County *Springfield* Registration District No. *318*
 Township *Springfield* Primary Registration District No. *2001*
 City *Springfield* (No. *1313 W Florida*) Registered No. *1711* (Ward)

2. FULL NAME

(a) Residence. No. *1313 W Florida* 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)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Jan. 16 1927*

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

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

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

10. NAME OF FATHER *J. R. Roeben*

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

12. MAIDEN NAME OF MOTHER *Josephine Pullar*

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

14. INFORMANT *J. R. Roeben*
 (Address) *1313 W Florida*

15. FILED *2/23 29* *Cl. Horst* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *2-22-1929*

17. I HEREBY CERTIFY, That I attended deceased from *2-22-1929* to *2-22-1929*, 19*29*
 that I last saw him alive on *2-22-1929*, and that death occurred, on the date stated above, at *Springfield, Mo.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia Bronchial
10:19A

CONTRIBUTORY (SECONDARY) *10:19A*

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) *C. E. Fuller*, 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.
Springfield

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Greenwood Cem* DATE OF BURIAL *Feb 29 1929*

20. UNDERTAKER *W. J. Stoney* 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

WRITE FULLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

