

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

Do not use this space.

24 1929

Sumner
10264

PLACE OF DEATH

County Greene Registration District No. 318
Township Springfield Primary Registration District No. 2001
City Springfield (No. Protestant Hospital) St. _____ Ward _____

File No. _____
Registered No. V15
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. Rogersville Pk 2 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 71 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown 1888
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 41 Unknown

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Greene Co.
(STATE OR COUNTRY)

10. NAME OF FATHER Robt. Hooper

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

12. MAIDEN NAME OF MOTHER Peta Logg

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

14. INFORMANT Ea. Nelsay
(Address) Rogersville Mo

15. 3/8 1929 Alb. Host REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-4-29

17. I HEREBY CERTIFY, That I attended deceased from Feb 20, 1929, to March 4, 1929 that I last saw her alive on March 4, 1929, and that death occurred, on the date stated above, at 7:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Appendicitis

1018 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) 1170 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? yes DATE OF Feb 28 1929

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Operation + clinical
(Signed) W. L. Turner, M. D.

(Address) Springfield Mo

*State the DISEASE CAUSING DEATH, or if death 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

Rodson Cem 3-8 1929

20. UNDERTAKER

Alma Schmeyer ADDRESS 5345 St. Louis

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.

235

