

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

Do not use this space.

10280

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be carefully supplied.

1. PLACE OF DEATH  
 County Greene Registration District No. 318  
 Township Springfield Primary Registration District No. 2001  
 City Springfield (No. 2020) Pierce St. \_\_\_\_\_ Ward \_\_\_\_\_  
 Registered No. 222

2. FULL NAME Mary A. Grey  
 (a) Residence No. 2020 Pierce St., \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3 MEDICAL CERTIFICATE OF DEATH**

3. SEX Female  
 4. COLOR OR RACE white  
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 31- 1885  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
72 9 8  
 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 \_\_\_\_\_

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/9 1929  
 17. I HEREBY CERTIFY That I attended deceased from 3-6, 1929 to 3-9, 1929 that I last saw h. or alive on 3-9, 1929 and that death occurred, on the date stated above, at 2:30 m.  
 THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Pneumonia  
 11A \_\_\_\_\_ (duration) yrs. mos. 3 ds.  
 10B \_\_\_\_\_  
 CONTRIBUTORY (SECONDARY) Chronic nephritis  
 (duration) unknown

9. BIRTHPLACE (CITY OR TOWN) Mo. (STATE OR COUNTRY)  
 10. NAME OF FATHER Enoch Arden  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Ny  
 12. MAIDEN NAME OF MOTHER Sarah E. Mauldy  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY) Va.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
 IF NOT AT PLACE OF DEATH, \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? No  
 WHAT TEST CONFIRMED DIAGNOSIS? Physical  
 (Signed) W. A. Walsh M. D.  
 (Address) Springfield Mo  
 \*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.

14. INFORMANT J. W. O'Brien  
 (Address) Springfield, Mo.  
 15. FILED 3-11-29 W. C. Frost M.D. REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL National Cemetery DATE OF BURIAL Mar 11 1929  
 20. UNDERLAYER Springfield, Mo. ADDRESS 424 E. Coml

USE OF DRAFT

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EXPERIMENTAL

1954

**MISSOURI STATE BOARD OF HEALTH  
BUREAU 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. 10280  
 Township \_\_\_\_\_ Primary Registration District No. 2001 Registered No. 222  
 City Springfield (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward)

**2. FULL NAME**

(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**

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hr. or \_\_\_\_\_ min.

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) (STATE OR COUNTRY)

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)

14. INFORMANT (Address)

15. FILED 3-11, 1929 Lon Sharp REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/9 1929

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 \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Pneumonia  
of bacterial origin  
of influenza  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 CONTRIBUTORY (SECONDARY) Chronic Nephritis  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED

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) \_\_\_\_\_

\*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

20. UNDERTAKER

ADDRESS

PHYSICIANS should state EXACT CAUSE OF DEATH in plain terms, so that it may be properly classified. FACT STATEMENT OF PHYSICIANS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

5-10280