

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

Do not use this space.
Feller

14401

1. PLACE OF DEATH

County *Greene*

Registration District No. *318*

Township *Springfield*

Primary Registration District No. *2007*

City *Springfield*

(No. *1951 N. Jefferson*)

File No. *334*
Registered No. *334*
St. _____ Ward)

2. FULL NAME

(a) Residence. No. *1951 N. Jefferson* 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) *married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Nellie G. Hamilton*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *1864-12-11*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
59 4 6

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Exp. R.R. Conductor*
(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) *Putaski Co., Mo.*

10. NAME OF FATHER *Unknown*

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

12. MAIDEN NAME OF MOTHER *Unknown*

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

14. INFORMANT (Address) *Don Hamilton Springfield, Mo.*

15. FILED *4-17-29* 19. *29* *Tom Sharp* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *4-17-1929*

17. I HEREBY CERTIFY, That I attended deceased from *4-11-1929* to *4-17-1929*, and that I last saw him alive on *4-15-1929*, and that death occurred, on the date stated above, at *6 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary TB
7 3/4
CONTRIBUTORY *Fracture by falling*
(SECONDARY) (duration) *2* yrs. mos. ds.

18. WHERE WAS DISEASE CONTACTED IF NOT AT PLACE OF DEATH

18. DID AN OPERATION PRECEDE DEATH? DATE OF _____ WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) *C. E. Feller*, M. D.

4-18, 1929 (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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
National Cemetery *April 19, 1929*

20. UNDERTAKER (ADDRESS) *J. W. Kingner & Co. 424 1/2 Court St. Springfield, Mo.*

MAY 25 1929
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.

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