

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

Do not use this space.

*Glynn*  
17831  
File No. ....  
Registered No. *392* .....  
St. .... Ward)

**1. PLACE OF DEATH**

County *Greene* Registration District No. *318*  
Township ..... Primary Registration District No. *2001*  
City *Springfield* (No. *914 So. Freemont*)

**2. FULL NAME**

(a) Residence. No. *914 So. Freemont* 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 *Anna*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *April 1 - 1876*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1	
				hrs.	min.
	<i>53</i>	<i>1</i>	<i>13</i>		

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work *Traveling Salesman*  
(b) General nature of industry, business, or establishment in which employed (or employer) .....  
(c) Name of employer .....

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

10. NAME OF FATHER *Jehus Le Due*

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

12. MAIDEN NAME OF MOTHER *Nancy J Redmon*

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

14. INFORMANT *Mrs Anna Le Due*  
(Address) *Springfield, Mo*

15. FILED *5-16-1929* *John Sharp* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *5/14* 19 *29*

17. I HEREBY CERTIFY, That I attended deceased from *April 15*, 19*29*, to *May 14*, 19*29*, that I last saw him alive on *May 14, 1929*, and that death occurred, on the date stated above, at *5:55 p. m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Cerebral hemorrhage with hemiplegia* (duration) yrs. mos. *12* ds.  
CONTRIBUTORY *Hypertensive pneumonia* (SECONDARY) (duration) yrs. mos. *3* ds.

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

19. DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

20. WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) *Robert Shynn* M. D.  
*5-15*, 19*29* (Address) *Springfield Mo.*

\*State the DISEASE CAUSING DEATH, or if deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

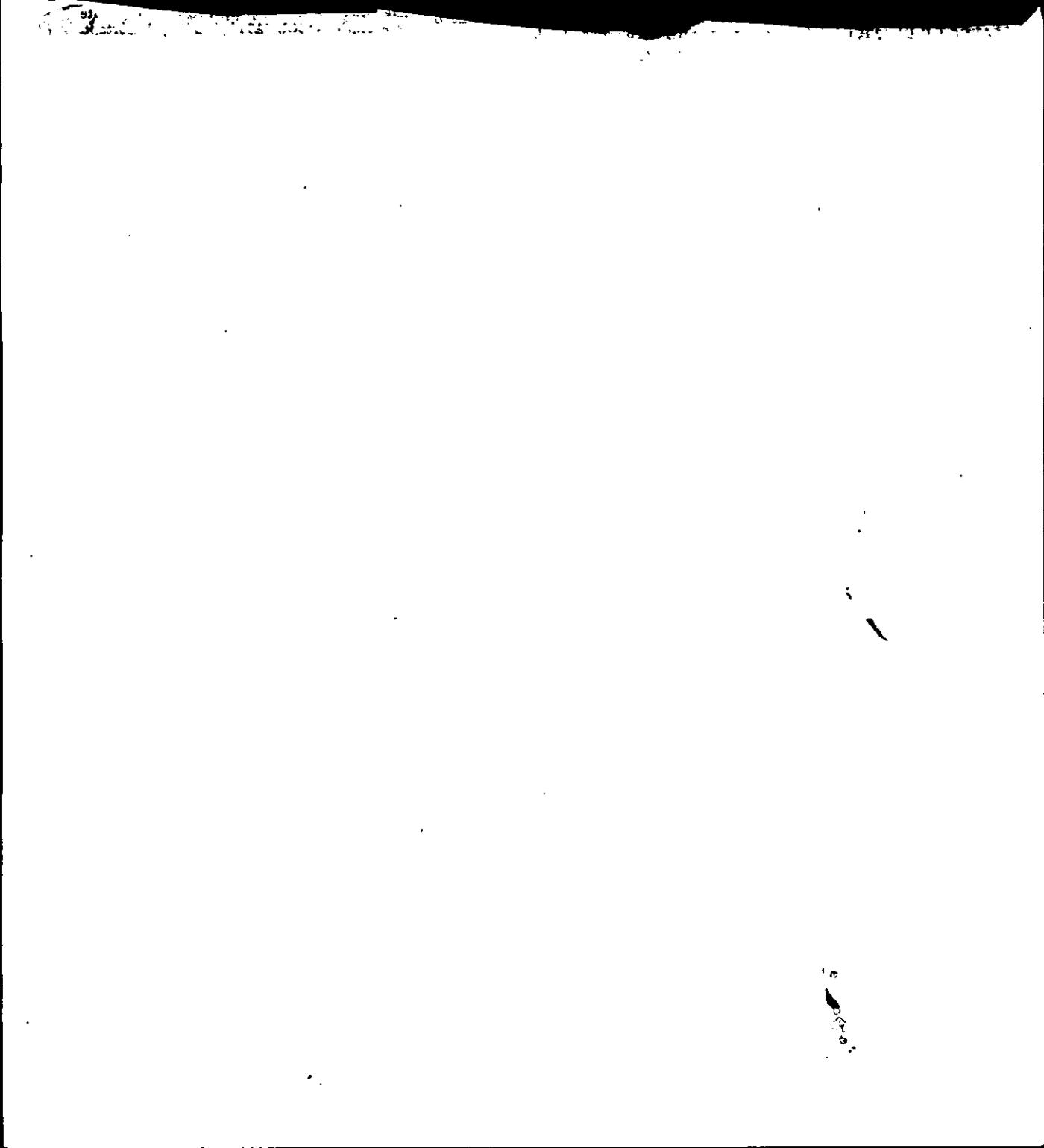
19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Maple Park* DATE OF BURIAL *5/16* 19 *29*

20. UNDERTAKER *Alma Schmeier* ADDRESS *Springfield*

CAUSE OF DEATH - Give full name of physician, so that it can be verified. Exact statement of OCCUPATION is very important.

179  
1  
2  
2

JUN 25 1929



**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. ....

Township Springfield

Primary Registration District No. 2001

Registered No. 394

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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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, .... hrs. 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)

**PARENTS**  
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 7/12, 1929 Low Sharp REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/14 1929

17. I HEREBY CERTIFY That I attended deceased from 11:00 to 11:00, 1929 that I last saw him alive on 5/14, 1929, and that death occurred, on the date stated above, at 11:00 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Cerebral hemorrhage with  
hemiplegia  
of Broncho Pneumonia  
(duration) .... yrs. .... mos. .... ds.  
CONTRIBUTORY (SECONDARY) Hypostatic pneumonia  
(duration) .... yrs. .... mos. .... ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH 7401  
DID AN OPERATION PRECEDE DEATH? NO  
WAS THERE AN AUTOPSY? NO  
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 19

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. If death occurs in plain terms, so that it may be clearly understood. REGISTRARS SHALL NOT RECEIVE A FEE. CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-17831