

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

Do not use this space.

File No. *1177*  
Registered No. *125*  
St. \_\_\_\_\_ Ward)

**25 1929**

**1. PLACE OF DEATH**

County *Boone* Registration District No. *318*  
Township *Springfield mo 217 W. Madison* Primary Registration District No. *2001*

**2. FULL NAME**

(a) Residence. No. *217 W. Madison* St. \_\_\_\_\_  
(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 *Female*  
4. COLOR OR RACE *white*  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widow*  
5A. IF MARRIED, WIDOWED OR DIVORCED HUSBAND OR (or) WIFE OF *Dr J W Nixon*  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 3 1856*  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *73 0 28*  
8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work *Housewife*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *6/1 1929*  
17. I HEREBY CERTIFY, That I attended deceased from *May 1*, 1929, to *6/1*, 1929, that I last saw her alive on *5/28*, 1929, and that death occurred, on the date stated above, at *5:30 p. m.*

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Hemiplegia*  
*(cerebral haemorrhage)*  
CONTRIBUTORY *arterio-sclerosis*  
(SECONDARY)  
(duration) *3* yrs. mos. da.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*  
10. NAME OF FATHER *W. D. Million*  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Mo*  
12. MAIDEN NAME OF MOTHER *Emily Staple*  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

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?  
(Signed) *J. B. Lemmon*, M. D.  
*Springfield Mo*

14. INFORMANT *Mrs. Emily Nixon*  
(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.

15. FILED *2*, 1929 *Tom Sharp* REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *W. Jones Mo* DATE OF BURIAL *Jul 3 1929*  
20. UNDERTAKER *W. H. Strayer* 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.

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