

JUL 25 1929

MISOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

Dr. Patten
21178

1. PLACE OF DEATH
County *Greene* Registration District No. *318*
Township *Springfield Mo* Primary Registration District No. *54892001*
City *Springfield Mo*

File No. _____
Registered No. *426* St. _____ Ward)

2. FULL NAME *Bertie Bernell Bragance*
(a) Residence No. *RR #1 - Box 81* 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

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female*
4. COLOR OR RACE *White*
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Infant*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Infant*
6. DATE OF BIRTH (MONTH, DAY AND YEAR) *May 28 - 1929*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *0 0 3 1/2*

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 1 - 1929*
17. I HEREBY CERTIFY That I attended deceased from *May 28 - 1929* to *June 1 - 1929* and that I last saw her alive on _____, 19____, and that death occurred, on the date stated above, at *9:00 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

CONTRIBUTOR (SECONDARY) *1610*
(duration) yrs. mos. da.

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

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

10. NAME OF FATHER *H. B. Bragance*

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

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

WHAT TEST CONFIRMED DIAGNOSIS? *Dr. Patten*
(Signed) _____, M. D.

12. MAIDEN NAME OF MOTHER *Bease Call*

6-1 - 1929 (Address) *Springfield Mo*

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

*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 *H. B. Bragance*
(Address) *RR #1 - Box 81*

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Greenwood cemetery* DATE OF BURIAL *7th June 1929*

15. FILED *6-1 - 1929* *J. W. Sharp* REGISTRAR

20. UNDERTAKER *T. W. Brown* 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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