

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

Do not use this space.

21195

JUL 25 1929
 PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important.
 N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important.
 CAUSE OF DEATH in plain terms, so that it may be properly classified.

PLACE OF DEATH
 County Greene Registration District No. 318
 Township Springfield Primary Registration District No. 2006
 City Springfield (No. 1909 N. Franklin)
 Registered No. 446 St. _____ Ward _____
 2. FULL NAME Malgie E. Hight
 (a) Residence. No. 1909 N. Franklin Ave 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 Female 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 J. Hight
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 7-1888
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
40 | 7 | 2
 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
 9. BIRTHPLACE (CITY OR TOWN) Mo. (STATE OR COUNTRY)
 10. NAME OF FATHER Pat O'Heron
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ireland (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Unknown
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown (STATE OR COUNTRY)
 14. INFORMANT J. Hight (Address) Springfield, Mo.
 15. FILED 6-10-1929 Geo Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-9 19 29
 17. I HEREBY CERTIFY, That I attended deceased from 5-7, 1929, to 6-9, 1929 that I last saw him alive on 6-9-29, 1929, and that death occurred, on the date stated above, at 12 m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary T.B.
93A
 (duration) 1 yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) 31
 (duration) _____ yrs. _____ mos. _____ ds.
 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) M. J. Armstrong, M. D.
6-10-1929 (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 DATE OF BURIAL
Manfield, Mo. June 11 19 29
 20. UNDERTAKER ADDRESS
J. W. Klingner & Co. 404 N. 4th St. Springfield, Mo.

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 1
 15
 31

