

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.

JUL 25 1929

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

Do not use this space.

21198

1. PLACE OF DEATH

County Greene Registration District No. 318
Township Springfield Primary Registration District No. 2001
City Springfield (No. 1020)
St. Mo. Ward

File No. _____
Registered No. 349
St. _____ Ward _____

2. FULL NAME

John J. Lair
(a) Residence No. 1020 E. Elm St. _____ Ward _____
(Usual place of abode)

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Ellen Lair

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 9 1845

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
83 6 1

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retd
(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) Ohio

10. NAME OF FATHER Michael Lair

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

12. MAIDEN NAME OF MOTHER Knabe

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

14. INFORMANT Ellen Lair
(Address) Springfield

15. FILED 6-10 19. 29 John Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 10 1929
17. I HEREBY CERTIFY, That I attended deceased from June 10 1929 to June 10 1929
that I last saw him alive on June 7 1929, and that death occurred, on the date stated above, at 11:15 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Coronary Arteriosclerosis
92A
95B
97

CONTRIBUTORY CAUSES (duration) _____ yrs. _____ mos. _____ ds.
Mitral Insufficiency
Arterio Sclerosis
(duration) _____ yrs. _____ mos. _____ ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) M. P. Halliday M. D.

610, 19 29 (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 Chillicothe Mo DATE OF BURIAL 6-11-1929

20. UNDERTAKER Alva Lohmeyer ADDRESS 534 st Lair

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