

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

Do not use this space.

24348

1. PLACE OF DEATH

County Greene

Registration District No. 318

File No. _____

Township _____

Primary Registration District No. 290

Registration No. 537

City Springfield

(No. Springfield Baptist Hospital)

St. _____ Ward) _____

2. FULL NAME

(a) Residence. No. 200 St., _____ Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

single

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

single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 7 1908

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>21</u>	<u>4</u>	<u>12</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Student
 (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)

Ark.

10. NAME OF FATHER J. W. Evans

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

Ark.

12. MAIDEN NAME OF MOTHER Annie Todd

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

Ark.

14. INFORMANT W. E. Evans
 (Address) 611 Whitson

15. FILED 7.16.29 For Sharp

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-14-29

17. I HEREBY CERTIFY That I attended deceased from July 10, 1929, to July 14, 1929, that I last saw him alive on July 14, 1929, and that death occurred, on the date stated above, at 9:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Meningitis Tubercula
29 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
32 (duration) yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) R. E. Cox, M. D.
7/15, 1929 (Address) 223 1/2 South

*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 East Lawn

DATE OF BURIAL 7-16-29

20. UNDERTAKER W. H. Harris

ADDRESS Springfield

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.

29 251

36 27 39 56 51 192

526