

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

SEP 3 1929

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.

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

Do not use this space.

27477

1. PLACE OF DEATH

County Greene Registration District No. 318
Township _____ Primary Registration District No. 2001
City Springfield Mo (No. 1215 E Thomas) _____ St. _____ Ward _____

File No. _____
Registered No. 589

2. FULL NAME

Infant of L. West
(a) Residence. No. 1215 E Thomas St. _____ 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) Infant
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 14 1929
7. AGE YEARS MONTHS DAYS If LESS than 1 day, 3 hrs. or _____ min.

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

9. BIRTHPLACE (CITY OR TOWN) Springfield Mo
(STATE OR COUNTRY)

10. NAME OF FATHER Lon West
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Stafford Mo
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Ruby Clark
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Springfield Mo
(STATE OR COUNTRY)

14. INFORMANT Lon West
(Address) 1215 E Thomas St

15. FILED 8-15 1929 Lon Sharp
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 14 1929
17. I HEREBY CERTIFY, That I attended deceased from 8-14, 1929 to 8-14, 1929 that I last saw h. live on, 8-14, 1929 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Infantile Peritonitis
(Stomach Birth)

159 159 (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Stomach Birth (duration) yrs. mos. ds.

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

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

20. WAS THERE AN AUTOPSY? no
WHAT TEST CONDUCTED? Chyngal
(Signed) Henry T. Keefe, M. D.

(Address) 8/-14 1929 1450 1/2 E. Canal

*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 Greenlawn Cem DATE OF BURIAL Aug 15 1929

20. UNDERTAKER F. C. Phelan ADDRESS Springfield Mo

639

1000