

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

Do not use this space.

Dr. Joe James
30532

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1. PLACE OF DEATH

County Greene Registration District No. 318 File No. _____
 Township _____ Primary Registration District No. 8001 Registered No. 634
Springfield (No. _____) St. Luke Hospital St. _____ Ward _____

2. FULL NAME

(a) Residence No. 609 W Central 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 F 4. COLOR OR RACE W 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) Sept 1 1929

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
1 1 1

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 _____

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

PARENTS

10. NAME OF FATHER O. S. Hubbard

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

12. MAIDEN NAME OF MOTHER Mable C. Veal

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

14. INFORMANT O. S. Hubbard
 (Address) 609 W Central

15. FILED 9-2-29 Lon Shep REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-2 1929

17. I HEREBY CERTIFY, That I attended deceased from 9-1 1929, to 9-2 1929, and that I last saw h. _____ alive on _____ 19____, and that death occurred, on the date stated above, at _____ 2 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Permaternity
159 / 158 (duration) yrs. mos. ds. 1 ds.
 CONTRIBUTORY (SECONDARY) acute placental separation
Placental separation of placenta (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) Joseph D James, M. D.
 (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 Springfield Cemetery DATE OF BURIAL Sept 2 1929

DR. UNDERTAKER Herman Schmeyer 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.

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