

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

Do not use this space.

30543

**1. PLACE OF DEATH**

County Greene

Registration District No. 218

Township Springfield

Primary Registration District No. 2904

City Springfield (No. 575 N. Locust)

File No. ....

Registered No. 670

St. .... Ward)

**2. FULL NAME**

(a) Residence. No. Welcome St., Jennings 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**

Male

**4. COLOR OR RACE**

white

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

Widowed

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

Unknown

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

April 15 - 1873

**7. AGE**

YEARS 86

MONTHS 6

DAYS 2

IF LESS than 1 day, .... hrs. or .... min.

**8. OCCUPATION OF DECEASED**

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

Retired Farmer

(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)

Jenn.

**10. NAME OF FATHER**

Unknown

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Unknown

**12. MAIDEN NAME OF MOTHER**

Unknown

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Unknown

**14.**

INFORMANT

(Address)

W. J. Murphy  
Springfield, Mo

**15.**

FILED

9-17-29  
Gov. Sharp Reg

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Sep 17 1929

**17.**

I HEREBY CERTIFY, That I attended deceased from .....

....., 19....., to ....., 19....., 19....., and that (that I last saw h. in ....., on ....., 19....., at ....., and that death occurred, on the date stated above, at ....., 9:30 m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Coronary Sclerosis

CONTRIBUTORY (SECONDARY)

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH? .....

**19. DID AN OPERATION PRECEDE DEATH?** h DATE OF .....

**20. WAS THERE AN AUTOPSY?** h

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) Anna C. Stone Coover, M. D.

Sep 17, 1929 (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**

**DATE OF BURIAL**

Fair Land, Okla

Sep 18 19 29

**20. UNDERTAKER** J. N. Klingner

ADDRESS Springfield, Mo

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.

WRITE PLAINLY WITH UNFADING INK

39  
5.5.29  
10

2

31

684