

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

Do not use this space.

30605

1. PLACE OF DEATH

County Greene Registration District No. 318
Township _____ Primary Registration District No. 2200
City Springfield (No. 903) St. Keller
St. _____ Ward _____

File No. _____
Registered No. 714
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 903 St. Keller 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male **4. COLOR OR RACE** white **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** married
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF _____
(OR) WIFE OF Mrs Della Hulhoit

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 28-1864

7. AGE YEARS MONTHS DAYS | If LESS than 1 day, _____ hrs. or _____ min.
65 | 3 | 2

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

9. BIRTHPLACE (CITY OR TOWN) _____
(STATE OR COUNTRY) Kentucky

10. NAME OF FATHER Michel Hulhoit

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

12. MAIDEN NAME OF MOTHER Margaret Crumb

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

14. INFORMANT Mrs. Della Hulhoit
(Address) Springfield, Mo

15. FILED 10-2 19 29 Geo. Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 30, 1929

17. I HEREBY CERTIFY That I attended deceased from 12-8 1928, to 9-30 1929
that I last saw h. m. alive on 9-30 1929 and that death occurred, on the date stated above, at 2:30 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Thrombosis of coronary arteries of heart

CONTRIBUTORY hypertension and indigestion
(SECONDARY) not known

18. WHETHER DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

19. OPERATION PRECEDE DEATH _____ DATE OF _____

WAS THERE AN AUTOPSY? no
WHICH TEST CONFIRMED DIAGNOSIS? clinical & physical
(Signed) Mary Jean Atteston, M. D.

10-1 19 29 Address 432-442 Medical Arts Bldg

*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 Maple Park **DATE OF BURIAL** Oct 1 1929

20. UNDERTAKER Oliver Schmeier **ADDRESS** Springfield

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

30605
1929
2

