39
JUN 23 1929
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# MISSOURI STATE BOARD OF HEALTH
## BUREAU OF VITAL STATISTICS
### CERTIFICATE OF DEATH

Do not use this space.

33462

1. PLACE OF DEATH
County Greene
Township
City Springfield Mo (No. ..... St. ..... Ward)
Registration District No. 218
Primary Registration District No. 2001
File No.
Registered No. 730

2. FULL NAME Infant of Mr Mrs Albert E Davis
(a) Residence No. 1823 So Neco 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.

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

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.

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Child
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 3 — 1929
7. AGE

| YEARS | MONTHS | DAYS | If LESS than 1 day, ..... hrs. or 30 min. |
|---|---|---|---|
| 0 | 0 | 0 | |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(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) Mo
PARENTS
10. NAME OF FATHER Albert E Davis
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Texas
12. MAIDEN NAME OF MOTHER Margaret O'Connor
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo
14. INFORMANT Albert E Davis
(Address) Springfield Mo
15. FILED 10-4, 1929 Lou Sharp REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/3 1929
17. I HEREBY CERTIFY, That I attended deceased from 10/3, 1929, to 10/3, 1929 that I last saw her alive on 10/3, 1929, and that death occurred, on the date stated above, at ..... m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Premature Birth
159
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) 1610
(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) Dr Cox, M. D
10/4, 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 Mt Moriah
DATE OF BURIAL Oct 4 1929
20. UNDERTAKER W H Schmeyer
ADDRESS Springfield Mo

7247