

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

Do not use this space.

Dr. Busiek
 File No. **763**
 Registered No. **4**

1. PLACE OF DEATH
 County Greene Registration District No. 918
 Township _____ Primary Registration District No. 2001
 City Springfield, Mo. (No. 1750 E. Atlantic) St. _____ Ward _____

2. FULL NAME Norma Esther Dowell
 (a) Residence No. 1750 E. Atlantic 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)
Child

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Child

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 6, 1926

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
3 5 25

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) Illinois
 (STATE OR COUNTRY)

10. NAME OF FATHER Acil Dowell

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

12. MAIDEN NAME OF MOTHER Mary E. Anderson

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

14. INFORMANT Mrs. Dowell
 (Address) 1750 E. Atlantic

15. FILED 1-2-30 G. G. Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 1 19 30

17. I HEREBY CERTIFY That I attended deceased from _____
12-24, 1929, to _____, 1930
 that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ 3 P. _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Diphtheria
10 16
93A
87A (duration) _____ yrs. _____ mos. 14 ds.
 CONTRIBUTORY Myocarditis acute, and
Polynueritis (duration) _____ yrs. _____ mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED Welfare Ho
 IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) Hubert Busiek, M. D.

1-2, 1930 (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 Stronghurst, Ill. DATE OF BURIAL 1-4-1930

20. UNDERTAKER Alma Schmeier ADDRESS Springfield Missouri
Funeral Home

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

N. E.--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.

FEB 18 1930

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