

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.

FEB 18 1930
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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

816

1. PLACE OF DEATH
 County Frank Registration District No. 318
 Township Springfield Primary Registration District No. 2901
 City Springfield (No. Springfield Hospital) St. _____ Ward) _____
2. FULL NAME Charles Madison Preston
 (a) Residence. No. 524 W Walnut St. _____ Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 1 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) single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF single
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 5 1924
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
5 4 18
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.
10. NAME OF FATHER Paul Preston
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Opal Orr
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.
14. INFORMANT Paul Preston
 (Address) 524 W Walnut
15. FILED 1-23-30 For Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-23-1930
17. I HEREBY CERTIFY, That I attended deceased from 1-17-30, 1930, to 1-23-30, 1930, that I last saw h. alive on 1-27-30, 1930, and that death occurred, on the date stated above, at 11:20 m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute intestinal obstruction
(Intussusception)
12.2 B
12.9 (duration) 1 mo. 1 ds.
CONTRIBUTORY (SECONDARY) Sherris 18 B2
Local colic peritonitis (duration) 1 yrs. 1 mo. 1 ds.
18. WHERE WAS DISEASE CONTRACTED Home
 IF NOT AT PLACE OF DEATH? _____
19. DID AN OPERATION PRECEDE DEATH? yes DATE OF _____
20. WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) Urban Busiek, M. D.
1/23/30 (Address) Springfield Mo.
 *State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.
19. PLACE OF BURIAL, CREMATION, OR REMOVAL Lockwood Mo. **DATE OF BURIAL** 1-25-30
20. UNDERTAKER W. H. Brown **ADDRESS** Walnut
Missouri

