

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

Do not use this space.

see H 7 rear
835

1. PLACE OF DEATH

County *Greene* Registration District No. *318*
Township *Springfield No* Primary Registration District No. *2951*
(No. *217 Broadway*)

File No. *835*
Registered No. *86* Ward

2. FULL NAME

(a) Residence. No. *2176 Broadway* 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

MEDICAL CERTIFICATE OF DEATH

3. SEX *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed*

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 28 1930*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (or) WIFE of

17. I HEREBY CERTIFY, That I attended deceased from *Jan 23* 19*30*, to *Jan 28* 19*30*, and that I last saw her alive on *Jan 28* 19*30*, and that death occurred, on the date stated above, at *E* P. M.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Jan 9 - 1848*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *82 0 19*

Bright Disease of Kidney
13 P.M.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Widowed*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

CONTRIBUTORY (SECONDARY) *12/13*

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) *United*

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

10. NAME OF FATHER

Unknown

DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *United*

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) *U. F. Kerr* M. D.
Jan 30, 1930 (Address) *610 Woodruff Bldg*

12. MAIDEN NAME OF MOTHER

Unknown

*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.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *United*

14.

INFORMANT *By Lee Spencer*
(Address) *Springfield Mo*

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *W. Marys* DATE OF BURIAL *1-31 1930*

15.

FILED *1-30-30* 19*30* *For Sharp* REGISTRAR

20. UNDERTAKER *W. Marys*
W. H. Shover 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.

1930
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