MAR 25 1930

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

Do not use this space.

4687

1. PLACE OF DEATH Dr Feller

County Greene Registration District No. 318 File No.

Township Campbell Primary Registration District No. 2001 Registered No. 166

City Springfield Mo (No. 512 S Robberson Ave St. Ward)

2. FULL NAME Infant of Mr Mrs Charley Hendricks

(a) Residence. No. 512 S Robberson St., Ward. (If nonresident give city or town and State)
(Usual place of abode)

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: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Infant

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Infant

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Feb 18 - 1930

7. AGE: — YEARS: — MONTHS: — DAYS: — If LESS than 1 day, 6 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(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: Charley Hendricks
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Mo
12. MAIDEN NAME OF MOTHER: Ruby Stowel
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mo

14. INFORMANT: Charley Hendricks
(Address) 512 S Robberson

15. FILED 2-20, 1930 Lon Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 5 pm Feb 18 1930

17. I HEREBY CERTIFY, That I attended deceased from Still Born, 19..., to ..., 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at ... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature Del
6 Month
159 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
161 W (duration) yrs. mos. ds.

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

0 DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) C. L. Feller, M. D

2-19-, 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: East Lawn Cemetery
DATE OF BURIAL: Feb 20 1930

20. UNDERTAKER: W. E. Staine
ADDRESS: Walnut [illegible]

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.

166