

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

Do not use this space.

4958

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Kean Primary Registration District No. 1000 Registered No. 15157
 City Kansas City (No. Kansas City General Hosp. St.) Ward _____

2. FULL NAME

Betty Springer
 (a) Residence. No. 925 Cherry St. 2 Ward. _____ (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 F. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 3 - 1926

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
4 | 1 | 5

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) San Diego Calif (STATE OR COUNTRY)

10. NAME OF FATHER Wm. Burton Springer

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

12. MAIDEN NAME OF MOTHER Beulah Murchison

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

14. INFORMANT Beard Clark (Address) Kansas City General Hosp

15. FILED 2/9 1930 J. M. Brown REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH Saturday

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2 - 8 1930

17. I HEREBY CERTIFY, That I attended deceased from 2-6 1930 to 2-8 1930 that I last saw her alive on 2-8 1930, and that death occurred, on the date stated above, at 4:50 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia
repeated 107A
130
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 100%
 (duration) yrs. mos. ds.

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

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

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) E. Williams M. D.
 1930 (Address) 8 apt 16 Canal Hosp

*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 Feb 10 1930

20. UNDERTAKER Eyles Funeral Home ADDRESS 1800 Leewood

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.

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