MAY 26 1930

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

Do not use this space.

12306

1. PLACE OF DEATH
County Greene
Township
City Springfield (No. 315 S. Florence St. Ward)
Registration District No. 318
Primary Registration District No. 2001
File No.
Registered No. 306

2. FULL NAME Mary Elizabeth Huttamus
(a) Residence. No. 315 S. Florence 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: Fem
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): widow

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: John Huttamus

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Apr. 5 - 1845

7. AGE: Years 85 | Months 0 | Days 9 | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(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): Germany

PARENTS
10. NAME OF FATHER: Wm Erskelstein
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Germany
12. MAIDEN NAME OF MOTHER: Gertrude Lankin
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Germany

14. INFORMANT: Mrs. H. C. Leslie
(Address) 315 S. Florence

15. FILED 4-15 1930 Lon Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-14 1930

17. I HEREBY CERTIFY, That I attended deceased from ___, 19__, to 4-14, 1930 that I last saw her alive on 4-14, 1930, and that death occurred, on the date stated above, at 6 30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Influenza
112
162
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (SECONDARY): Senility
(duration) yrs. mos. ds.

118

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS?

4/15 1930 (Signed) C. E. Feller, M.D.
(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: Richfield Mo.
DATE OF BURIAL: 4-16 1930

20. UNDERTAKER: W. Sharp
ADDRESS: Mark W

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.

WITH UNFADING INK—THIS IS A PERMANENT RECORD