

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

Do not use this space.

12312

1. PLACE OF DEATH

County Greene
Township Springfield
City Springfield

Registration District No. 9+8
Primary Registration District No. 2021

File No. _____
Registered No. 314
Ward _____

2. FULL NAME

(a) Residence, No. Cabot No. 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 m 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 single

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 2 1880

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
49 | 11 | 14

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer
(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) West Va.

10. NAME OF FATHER John Annous

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) W. Va.

12. MAIDEN NAME OF MOTHER Lady C. Huntington

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) W. Va.

14. INFORMANT J. S. Annous
(Address) Seymour Iowa

15. FILED 4-17, 1930 For Sharp
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from 4-14-30, 1930, to 4-16-1930, and that I last saw him alive on 4-16-1930, and that death occurred, on the date stated above, at 8:20 PM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Interruption (Bowel)

122 B (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

11801 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

H (Signed) D. Cavalier, M. D.

17, 1930 (Address) Cabot No.

*State the DISEASE CAUSING DEATH or INFERRED from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Seymour Iowa

DATE OF BURIAL

4-18-1930

20. UNDERTAKER

[Signature]

ADDRESS

Wagon
[Signature]

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.

MAY 26 1930

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