

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

Do not use this space.

19126

File No. ....  
Registered No. 425  
St. .... Ward)

**1. PLACE OF DEATH**

County Greene Registration District No. 318  
Township Springfield Primary Registration District No. 2001  
City Springfield (No. 1146 N Bud)

**2. FULL NAME**

Edith Sue Mc Guire  
(a) Residence. No. 1146 N Bud 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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Infant</u>
-------------------------	----------------------------------	---

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 29 - 1930

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ..... hrs. or ..... min.
			<u>6</u>	

**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) Springfield  
(STATE OR COUNTRY) Mo

10. NAME OF FATHER G S Mc Guire

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

12. MAIDEN NAME OF MOTHER Ethel Fender

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

14. INFORMANT G S Mc Guire  
(Address) 1146 N Bud

15. FILED 6-4, 1930 G S Mc Guire REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

17. I HEREBY CERTIFY, That I attended deceased from May 29, 1930 to June 4, 1930 that I last saw her alive on June 2, 1930, and that death occurred, on the date stated above, at 1:30 P m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Premature birth

159 duration 16/10 yrs. 0 mos. 0 ds.

CONTRIBUTORY (SECONDARY)

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? clinical  
(Signed) D. F. Truman M. D.

6/4, 1930 (Address) Springfield Mo

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Brighton Gro</u>	DATE OF BURIAL <u>June 5 - 1930</u>
---	--

20. UNDERTAKER <u>D. W. Thompson &amp; Co</u>	ADDRESS <u>424 E Canal St</u>
--	----------------------------------

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

4211