

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

Do not use this space.

19143

1. PLACE OF DEATH
 County Greene Registration District No. 318
 Township Springfield Primary Registration District No. 200
 City Springfield (No. 1205) Caro St. _____ Ward _____
 2. FULL NAME Martin L. Ames
 (a) Residence No. 1205 Caro 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widower
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 14 1854

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 3 24

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Retired Miner
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Mo.
 (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Unknown
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Unknown
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY)

14. INFORMANT Hans H. Ames
 (Address) Springfield, Mo.

15. FILED 6-9-30 For Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 8th 1930
 17. I HEREBY CERTIFY, That I attended deceased from May 26th 1930, to June 8th 1930 that I last saw him alive on July 8th 1930, and that death occurred, on the date stated above, at _____ p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonia followed by pneumonia left lung
5th Bronchio Pneumonia
 (duration) yrs. 1 mos. ds.
 CONTRIBUTORY (SECONDARY) Tuberculosis (duration) yrs. mos. 1 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. L. Evans M. D.
6/9 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 Galena Kan. DATE OF BURIAL 6-10-1930
 20. UNDERTAKER Wm. K. ... ADDRESS Springfield Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. AGE should be stated EXACTLY. PHYSICIAN should state every item of information should be carefully supplied.

