

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

Do not use this space.

Dr Carl
19161
File No. 464
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH

County Greene Registration District No. 318
Township _____ Primary Registration District No. 318
City Springfield (No. 150th Street) St. _____ Ward _____

2. FULL NAME

(a) Residence No. 800 W. Grand 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>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Wm. Gardner</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Mar 21 1854</u>		
7. AGE <u>76</u>	YEARS <u>2</u>	MONTHS <u>24</u>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Owner</u> (b) General nature of industry, business, or establishment in which employed (or employed) <u>Owner</u> (c) Name of employer		

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 15 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1 1930 to June 14 1930 that I last saw her alive on 4/10 1930, and that death occurred, on the date stated above, at 4 15 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cancer of liver
4413

CONTRIBUTORY (SECONDARY) 4413
(duration) yrs. mos. ds.

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

10. NAME OF FATHER John Mobley

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

12. MAIDEN NAME OF MOTHER Mrs. A. Nathan

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

14. INFORMANT John Mobley
(Address) Springfield

15. FILED 6-17-30 For Sharp
REGISTRAR

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WHAT TEST CONFIRMED DIAGNOSIS
(Signed) R. H. Coe M. D.
4/17 1930 (Address) 223 1/2 South

*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.

21. PLACE OF BURIAL, CREMATION, OR REMOVAL Maple Park DATE OF BURIAL June 17 30

22. UNDERTAKER W. J. Shroyer ADDRESS Springfield

N. E.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

