

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

Do not use this space.

Dr. Rayl 19170

1. PLACE OF DEATH

County *Greene* Registration District No. *318*
Township *Springfield* Primary Registration District No. *200th*
City *Springfield* (No. *112 N. Grant*) St. _____ (Ward)

File No. _____
Registered No. *473*

2. FULL NAME

(a) Residence. No. *112 N. Grant* St. _____ (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*) *married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Feb 25 1859*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
71 3 22

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Lawrence*
(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) *Ill. Tolbert*

10. NAME OF FATHER *Tolbert*

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

12. MAIDEN NAME OF MOTHER *"*

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

14. INFORMANT (Address) *Martha Carson 112 N. Grant*

15. FILED *18 30* *For Grant* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 17 1930*

17. I HEREBY CERTIFY, That I attended deceased from *June 12*, 19*30* to *June 14*, 19*30* that I last saw her alive on *June 14*, 19*30* and that death occurred, on the date stated above, at *11:30 a. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Paralysis (apoplexy)
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) *74*
(duration) _____ yrs. _____ mos. _____ ds.

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

8 DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? *No*

WHAT TEST CONFIRMED DIAGNOSIS? *No*
(Signed) *J. E. Rayl, M. D.*

June 18 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 DATE OF BURIAL
Maple Run *Feb-19 1930*

20. UNDERTAKER ADDRESS *1117 Sumner Springfield*

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.

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