

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

Do not use this space.

19174

PLACE OF DEATH

County Greene
Township Springfield
City Springfield (No. Burge Hospital)

Registration District No. 3/8
Primary Registration District No. 12001

File No. 477
Registered No. 477
St. _____ Ward _____

2. FULL NAME

Infant son of Isabell M. Cafrey (Illegitimate)

(a) Residence. No. 1413 N. Grant 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 (only the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 19-1930

7. AGE YEARS MONTHS DAYS IT LESS than 1 day, hrs. or min.
0 0 0 3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant
(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 Harold Brown

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

12. MAIDEN NAME OF MOTHER Isabell M. Cafrey

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

14. INFORMANT Verma M. Cafrey
(Address) Springfield, Mo.

15. FILED 6-19-30 For Sharp
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/19 1930

17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____ that I last saw him alive on 6-19 1930, and that death occurred, on the date stated above, at 12:30 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Premature (7 mos).
159
158 (duration) yrs. mos. ds. 3 hrs.

CONTRIBUTORY (SECONDARY) General myocardial weakness
(duration) yrs. mos. ds. _____

18. WHERE WAS DISEASE CONTRACTED 101 W
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 Physiognal
(Signed) W. T. Walsh M. D.

6-19-30 (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 East Lawn Cemetery DATE OF BURIAL June 20 1930

20. UNDERTAKER J. W. Klingner & Co., Springfield Mo. ADDRESS 424 1/2 Commercial

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 very important.

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