

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

Do not use this space.

49188

File No. _____
Registered No. 494
St. _____ Ward _____

1. PLACE OF DEATH

County Greene
Township _____
City Springfield

Registration District No. 318
Primary Registration District No. R 201

2. FULL NAME

Julia Isabelle Maher

(a) Residence. 553 W Webster 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

MEDICAL CERTIFICATE OF DEATH

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female wh single

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

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

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

10 3 15

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry, business, or establishment in which employed (or employer)
- (c) Name of employer

Child

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

MO

10. NAME OF FATHER

E. P. Maher

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

MO

12. MAIDEN NAME OF MOTHER

Julia Kennedy

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

MO

14. INFORMANT

(Address)

E. P. Maher
553 W Webster

15. FILED

6-27, 1930

For Sharp
REGISTRAR

3

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

June 20, 1930

17. I HEREBY CERTIFY, That I attended deceased from
June 17, 1930, to June 25, 1930.
that I last saw h. & a. alive on June 25, 1930, and that death occurred, on the date stated above, at 11:45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mixed Infection Throat
Streptococci, Pneumococci

98 hrs (duration) yrs. mos. 15 ds.

CONTRIBUTORY (SECONDARY) Hayfever soft palate

36 (duration) yrs. mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED

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? Wettest

(Signed) W. S. Shick M. P.

6-27-1930 (Address) 600 Melied Arts Bldg

*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

DATE OF BURIAL

Pierson City MO

6-28 1930

20. UNDERTAKER

ADDRESS

H. H. Labaree Springfield MO

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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1914

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Greene Registration District No. 218 File No. _____
 Township _____ Primary Registration District No. 2001 Registered No. 494
 City Springfield St. _____ Ward _____

2. FULL NAME

Julia Isabell Maher

(a) Residence No. _____ St. _____ Ward _____ (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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S

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

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

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 9/27 19. 1908 John Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 25 19 30

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

THE CAUSE OF DEATH WAS AS FOLLOWS: Infection Throat
Streptococci
Pneumococcus
Conjunctivitis (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Not-Neurypoid
Gangrene soft palate (duration) _____ yrs. _____ mos. _____ 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) _____, M. D. _____, 19____ (Address)

*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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

MISSOURI STATE BOARD OF HEALTH SUPPLEMENTARY

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