

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

Do not use this space.

19194

1. PLACE OF DEATH

County Greene
Township Springfield
City Springfield (No. 1120 E. Pacific)

Registration District No. 318
Primary Registration District No. 2001

File No. _____
Registered No. 501
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 1120 E. Pacific 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>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>San Young</u>				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Aug 8 - 1855</u>				
7. AGE	YEARS <u>74</u>	MONTHS <u>10</u>	DAYS <u>21</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>House wife</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer				

MEDICAL CERTIFICATE OF DEATH

4

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 29 - 1930

17. I HEREBY CERTIFY, That I attended deceased from about March 1, 1930, to June 29, 1930 that I last saw her alive on June 29, 1930, and that death occurred, on the date stated above, at 12 Noon

THE CAUSE OF DEATH WAS AS FOLLOWS:
Broncho Pneumonia
186A
194B
73A (duration) _____ yrs. _____ mos. 10 ds.

CONTRIBUTORY (SECONDARY) Chronic Pyloric HPC -
Nail bit - 4 mo ago (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) E. Merreudan, M. D.
June 30, 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 <u>Green Lawn Cemetery</u>	DATE OF BURIAL <u>July 1 1930</u>
20. UNDERTAKER <u>W. Kingner & Co., Springfield, Mo.</u>	ADDRESS <u>424 C. Court</u>

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

10. NAME OF FATHER Robert Chalmers

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

12. MAIDEN NAME OF MOTHER Ellen Smith

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

14. INFORMANT San Young
(Address) Springfield, Mo.

15. FILED 7-1-30 Yon Sharp
REGISTRAR

N. B.—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.

5-10-02

D. F. Asenden

requested to make every effort to obtain the following information indicated by check marks, lacking from the death certificate:

Name: Isabelle Young
Who died at: Springfield, Mo. on June 29, 1930
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex: _____ Color or race: _____ Single, married, widowed or divorced: _____

Date of birth: _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade _____ (b) Industry: _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

CAUSE OF DEATH: Bronchopneumonia

Contributory: Chronic Pulmonary T.B.C.
Fractured hip 4 months ago.

Where was disease contracted? from fall at home

Did operation precede death? _____ Date of _____

What test confirmed diagnosis?

S-19194