

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

Do not use this space.

19200

1. PLACE OF DEATH

County Greene
Township M. Campbell
City Springfield

Registration District No. 318

File No. 480

Primary Registration District No. 5451
(No. Greene County Hospital T.B.)

Registered No. 480

St. Mo. Ward

2. FULL NAME

(a) Residence. No. Greene County Hospital St. Mo. 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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 11 - 1879
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ... hrs. or ... min.
51 | 1 | 9 | |

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

10. NAME OF FATHER Geo. Orey

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

12. MAIDEN NAME OF MOTHER Don't know

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

14. INFORMANT Mrs. Orey
(Address) 676 1/2 Main

15. FILED 628, 1920 Gov. Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-20 1920

17. I HEREBY CERTIFY, That I attended deceased from Jan 4, 1920 to 6-20, 1920
that I last saw alive on 6-18, 1920, and that death occurred, on the date stated above, at 6:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tbc Meningitis
23A
24A (duration) yrs. mos. 5 ds.

CONTRIBUTORY (SECONDARY) Pulmonary Tbc
(duration) yrs. 6 mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? Physical - Laboratory
6 (Signed) J. H. Williams, M. D.
121 (Address) Springfield Mo.

*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 Mount Mo. DATE OF BURIAL 6-22 1920

20. UNDERTAKER ADDRESS

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.

JUL 22 1920

48'