

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

Do not use this space.

22529

1. PLACE OF DEATH

County Greene
Township Springfield
City Springfield (No. 957)

Registration District No. 318
Primary Registration District No. 2401
St. Kimberly Ward

File No.
Registered No.
St. Ward)

2. FULL NAME

(a) Residence. No. 957 S. Kimbrough St. Kimberly 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 MEDICAL CERTIFICATE OF DEATH

3. SEX Male
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widower

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 11 - 1930

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1928, to July 1, 1930 that I last saw him alive on July 1, 1930 and that death occurred, on the date stated above, at 3:30 P. m.

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fracture head of femur from a fall, accidentally incurred 1860
1945 (duration) 0 yrs. 0 mos. 15 ds.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sep 16 1841
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 89 9 25

CONTRIBUTORY (SECONDARY) Senility (duration) 8 yrs. 0 mos. 0 ds.

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

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

0 DID AN OPERATION PRECEDE DEATH? no DATE OF

10. NAME OF FATHER Charles M. Breech

WAS THERE AN AUTOPSY? no

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

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Don R. Selsby, M. D.

12. MAIDEN NAME OF MOTHER Ester Colvert

July 12, 1930 (Address) Springfield, Mo.

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

*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.

14. INFORMANT (Address) J. G. Breech
Springfield, Mo.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL National Cemetery

DATE OF BURIAL July 12 1930

15. FILED 7-12-30 For Sharp REGISTRAR

20. UNDERTAKER J. W. Klingner & Co. ADDRESS Springfield, Mo.

Exact statement of OCCUPATION is very important.

1930

95

32

**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 Suicide Registration District No. 318 File No. _____
 Township _____ Primary Registration District No. 2101 Registered No. _____
 City Springfield (No. _____) St. _____ Ward _____

2. FULL NAME Simon Breach

(a) Residence. No. _____ 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 M 4. COLOR OR RACE W 5. SINGLE/MARRIED, WIDOWED OR DIVORCED (write the word) wid

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 7/12 19 30 Gon Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 11 19 30

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fracture Head of Femur from a fall (accident) fell in home
 (duration) _____ yrs. _____ mos. _____ ds.

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

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

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 _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-22529