

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

Do not use this space.

22580

1. PLACE OF DEATH

County Greene Registration District No. 318
Township Springfield Primary Registration District No. 2001
City Springfield (No. 1813 N. Main

File No. _____
Registered No. 570
St. _____ Ward) _____

2. FULL NAME

(a) Residence. No. 1813 N. Main 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 Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widow (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 28 - 1853

7. AGE YEARS MONTHS DAYS IT LESS than 1 day, _____ hrs. or _____ mts.
75 4 22

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Ill Belleville
(STATE OR COUNTRY)

10. NAME OF FATHER Newitt Drew

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

12. MAIDEN NAME OF MOTHER Wolderman

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

14. INFORMANT J. M. Mc Nier
(Address) Springfield - Mo.

15. FILED 7-23-30 John Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 22 1930

17. I HEREBY CERTIFY, That I attended deceased from 7-1-30 to 7-22-30 that I last saw him alive on 7-22-30, and that death occurred, on the date stated above, at 9:00 A. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Acute Scleritation of Heart
97
133C
95P (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Renal-Vascular Disease (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? Clinical
(Signed) Henry T. Knapp, M. D.

7/27, 1930 (Address) 440 1/2 E Canal

*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 Maple Park Cemetery DATE OF BURIAL July 23, 1930

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

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.

WHILE LIVING, WITH AN ADVERSE EFFECT ON THIS IS A PERMANENT RECORD

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