

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

Do not use this space.

22588

**1. PLACE OF DEATH**

County Greene

Registration District No. 318

File No. \_\_\_\_\_

Township Springfield

Primary Registration District No. 2011

Registered No. 582

City Springfield (No. \_\_\_\_\_)

St. St. John Sharp Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. Battlefield mo St. Rd 1 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)**

Child

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

\_\_\_\_\_

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

Dec 21 - 1929

**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

7 8

**8. OCCUPATION OF DECEASED**

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

Infant

(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)

mo

**10. NAME OF FATHER**

L. E. Adams

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

mo

**12. MAIDEN NAME OF MOTHER**

Hazel Marie

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Okla.

**14.**

INFORMANT

(Address)

L. E. Adams

Battlefield mo

**15.**

FILED

7-29, 1930

John Sharp

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

17.

HEREBY CERTIFY, That I attended deceased from July 25, 1930, to July 29, 1930, that I last saw him alive on July 29, 1930, and that death occurred, on the date stated above, at \_\_\_\_\_.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Acute Necrotic

119B

113B

(duration) yrs. mos. 3 ds.

CONTRIBUTOR (SECONDARY)

(duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH

Battlefield R.I.

DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

physical

(Signed) John William M. D.

(Address) Springfield

\*State the DISEASE CAUSING DEATH, or in months 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

Hall. Cem.

7-30 1930

**20. UNDERTAKER**

ADDRESS

H. H. Schmay Jr. Springfield

PARENTS

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PREVIOUS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important.

ALL INFORMATION SHOULD BE STATE  
CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS IMPORTANT.

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