

SEP 24 1930

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

Do not use this space.

26412

1. PLACE OF DEATH

County Frank

Registration District No. 218

File No. 26412  
Registered No. 620  
St. \_\_\_\_\_ Ward \_\_\_\_\_

Township \_\_\_\_\_

Primary Registration District No. 299

City Springfield (No. Spring. Baptist Hospital)

2. FULL NAME

(a) Residence. No. R. F. D. # 1 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Male

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Student

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-14-30

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Student

17. I HEREBY CERTIFY, That I attended deceased from 8-1-30 to 8-14-30

that I last saw her alive on 8-14-30, and that death occurred, on the date stated above, at 8:15 PM m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 4 1920

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 10 0 10

fracture of base of brain caused by accident fall from horse on farm 8 miles S.W. of Springfield

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student 218  
(b) General nature of industry, business, or establishment in which employed (or employer) 218  
(c) Name of employer

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) yrs. mos. ds.

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

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

10. NAME OF FATHER Crow D. Mowley

DID AN OPERATION PRECEDE DEATH? no DATE OF 8-14-30

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

WAS THERE AN AUTOPSY? no

12. MAIDEN NAME OF MOTHER Helen K. Knicker

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_

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

(Signed) [Signature] M. D.

14. INFORMANT Crow D. Mowley (Address) R. F. D. # 1

1930 (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.

15. FILED 8-16-30 [Signature] REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Hazelwood DATE OF BURIAL 8-16-30

20. UNDERTAKER [Signature] ADDRESS [Signature]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGES should be stated EXACTLY. PHYSICIANS should state information should be carefully supplied.

terms, so that it may be necessary to  
them should be carefully supplied.  
Exact statement of the

**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 Greene Registration District No. 918 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 9001 Registered No. 620  
 City Springfield (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S  
 (write the word)  
 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 8/16 30 1930 Lon Sharp REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/14 1930  
 17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_ alive \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, \_\_\_\_\_, 19\_\_\_\_.

THE CAUSE OF DEATH WAS AS FOLLOWS:  
Fractured at base of brain  
caused by accident fall  
from horse at high  
speed (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 CONTRIBUTORY (SECONDARY) of Springfield (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
 (Signed) \_\_\_\_\_ 66, 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 \_\_\_\_\_ 19\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

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

SUPPLEMENTARY

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