SEP 24 1930

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

Do not use this space.

26420

1. PLACE OF DEATH
County Green Co. Registration District No. 318 File No. 630
Township Primary Registration District No. 2001 Registered No.
City Springfield (No. Springfield B Hospital Ward)

2. FULL NAME Margaret Marie Towe.
(a) Residence. No. Mansfield Mo. 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. 1 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE Wht 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) Mar. 9 - 1924

7. AGE Years 6 Months 5 Days 10 If LESS than 1 day, ... hrs. or ..... min.

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

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

PARENTS
10. NAME OF FATHER Medley Towe.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mansfield
(STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Winnie M. Johnson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Mo.

14. INFORMANT Medley Towe
(Address) Mansfield

15. FILED 8/20 1930 Ron Sharp REGISTRAR

3

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8 - 19 - 1930

17. I HEREBY CERTIFY, That I attended deceased from 6-17-, 1930, to 6-18, 1930 that I last saw her alive on 6-18, 1930, and that death occurred, on the date stated above, at 6.20 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tonsillitis acute
(duration) yrs. mos. 8 ds.

CONTRIBUTORY (SECONDARY) Septicemia - multiple abscesses (duration) yrs. mos. 6 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? home
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Blood Culture
(Signed) [signature], M.D.
8-19, 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Fairview DATE OF BURIAL 8-20 1930

20. UNDERTAKER F. A. Steffe ADDRESS Mansfield

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.

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. 218 — File No. .....

Township ..... — Primary Registration District No. 2001 — Registered No. 630

City Springfield (No. ....., ... St. ..... Ward)

2. FULL NAME Margaret Marie Towe

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*)
F	W	S

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)

PARENTS

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. X FILED ....., 19..... ..... REGISTRAR X

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/19 1930

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:

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Septicemia - multiple abscesses caused from blood stream infection, organism not determined (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) ....., M. D
, 19 (Address)

1530

*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

SUPPLEMENTARY

N. B. ... item ... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIA... state CAUSE OF DEATH ... plain term ... that it may be properly classified. Exact statement of OCCUPATION i... ry important. REGIS... HAL ... ECE... FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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