

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

Do not use this space.

26430

SEP 24 1930

1. PLACE OF DEATH

County Greene
Township Springfield
City Springfield (No. 1336)

Registration District No. 918
Primary Registration District No. 2001
Ward Jefferson

File No. _____
Registered No. C40
St. _____ Ward _____

2. FULL NAME

(a) Residence No. 1336 St. Jefferson 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 15-1874

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
82 3 8

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

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

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT (Address) Emma Dickey
Springfield, Mo.

15. FILED 8-25, 1930 John Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 23- 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 23-, 1930, to Aug 23-, 1930 that I last saw him alive on Aug 23-, 1930, and that death occurred, on the date stated above, at 7:40 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
25 Myocarditis chronic
430

CONTRIBUTORY (SECONDARY) Pulmonary tuberculosis (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) G. M. Howell, M. D.

8-25, 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 Maple Park Cemetery DATE OF BURIAL Aug 25 1930

20. UNDERTAKER* H. C. Commercial ADDRESS Springfield Mo.

K. 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.

