

SEP 24 1930

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

Do not use this space.

26438

1. PLACE OF DEATH

County Franklin

Registration District No. 318

Township Springfield

Primary Registration District No. 2504

City Springfield (No. St. Johns Hospital)

File No. _____

Registered No. 649

St. _____ Ward _____

2. FULL NAME

(a) Residence No. 328 V. Sanford Ave. Ward _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 6 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)

male

W

widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF (OR) WIFE OF

Leola J. Duval

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 8-1845

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, _____ hrs. or _____ min.

85

7

18

8. OCCUPATION OF DECEASED

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

(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)

Paumotu

10. NAME OF FATHER

W. Patterson

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Paumotu

12. MAIDEN NAME OF MOTHER

Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Paumotu

14. INFORMANT

(Address)

O. J. Patterson
6 Selwicks Road

15. FILED

8-28-1930

Don Sharp
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-26-30

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Smility
apoplexy

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____ (duration) _____ yrs. _____ mos. _____ ds.

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH _____ DATE OF _____

WAS THERE AN AUTOPSY _____

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) James E. Dewey M. D.

27 . 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 _____ DATE OF BURIAL _____

Hoguelwood 8-28-30

20. UNDERTAKER _____ ADDRESS _____

W. Rowe 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.

