

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

Do not use this space.

Dr Busiek

1. PLACE OF DEATH

County *Greene*

Registration District No. *318*

Township *Springfield*

Primary Registration District No. *2971*

City *Springfield*

(No. *Springfield Baptist Hospital* St. *715* Ward)

2. FULL NAME

(a) Residence. No. *Stratford Mo. R#1* St. *R#1* Ward.

(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 *Female*
4. COLOR OR RACE *white*
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Dec 26-1928*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
1 8 26

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

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

10. NAME OF FATHER *Elston G. Jarrett*

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

12. MAIDEN NAME OF MOTHER *Hazel Jar*

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

14. INFORMANT *O. S. Jarrett*
(Address) *Stratford Mo. R#1*

15. FILED *9-22-30* *For Sharp* REGISTRAR

5 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *9-22 1930*

17. I HEREBY CERTIFY, That I attended deceased from *9-16*, 19*30*, to *9-22*, 19*30*, that I last saw her alive on *9-22*, 19*30* and that death occurred, on the date stated above, at *8-30 Pm*.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Dys colitis

119B
133A
42D (duration) yrs. mos. *14* ds.
CONTRIBUTORY *encephalitis acute*
(SECONDARY) *antidysentery antitoxin*
pye 2: ho
intestinal parasites (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH *Home*

IF DID AN OPERATION PRECEDE DEATH. *no* DATE OF.....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *Urban Busiek*, M. D.
9-22-1930 (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 *Stratford Mo.* DATE OF BURIAL *Dec 23 1930*
St Croix Cemetary

20. UNDERTAKER *424 E. Paul St* ADDRESS *Springfield Mo.*
J. N. Klingner & Co.

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.

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