

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.

NOV 22 1930

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

Do not use this space.

1. PLACE OF DEATH

County Greene

Registration District No. 318

File No. 32623

Township Springfield

Primary Registration District No. 2001

Registered No. 766

City Springfield (No. St. Johns Hospital)

St. _____ Ward) _____

2. FULL NAME

(a) Residence, No. 1118 G. Atlantic 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

Female

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

Vester Murphy

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

April 16-1900

7. AGE

YEARS

MONTHS

DAYS

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

30

5

24

8. OCCUPATION OF DECEASED

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

at Home

(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)

Mo.

10. NAME OF FATHER

Peter Goodman

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

12. MAIDEN NAME OF MOTHER

Peoria Miller

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Kan.

14.

INFORMANT

(Address)

Vester Murphy, Springfield, Mo.

15.

FILED

10-10, 1930

For Sharp

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 10 1930

17. I HEREBY CERTIFY. That I attended deceased from Oct 4th, 1930, to Oct 10, 1930

that I last saw him alive on Oct 9, 1930, and that death occurred, on the date stated above, at about 3 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Interstitial Nephritis

131

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

CONTRIBUTORY (SECONDARY)

1290

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no. DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

Microscope

(Signed) C. A. Mackey, M. D.

10/10, 1930 (Address) Springfield, Mo.

*State the DISEASE CAUSING DEATH, or in cases 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

Dassville, Gretna, Oct 10 1930

20. UNDERTAKER

424 E. Conild St.

ADDRESS

J. W. Klingner & Co., Springfield, Mo.

