

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

Do not use this space.

39126

1. PLACE OF DEATH

County Greene Registration District No. 318
 Township Springfield Primary Registration District No. 2nd Dist
 City Springfield (No. 1418) Irving Place St. _____ Ward _____

File No. _____
 Registered No. 970

2. FULL NAME

(a) Residence. No. 1418 Irving Place 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 OR (OR) WIFE OF Samuel G. Broley

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 31 - 1898

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
32 10 26

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work At Home 5
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

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

10. NAME OF FATHER Albert J. Mc. Part

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

12. MAIDEN NAME OF MOTHER Tina E. Prisma

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

14. INFORMANT S. G. Broley
 (Address) Springfield, Mo.

15. FILED 2-29-30 For Sharp
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-27-1930

17. I HEREBY CERTIFY, That I attended deceased from 12-20-1930 to 12-27-1930, and that I last saw him alive on 12-27-1930 at 3:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Diabetic Coma. Diabetic mellitus

possibly of 1-2 mo duration
as patient has been living
blind for that time (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Palvic Pathology but
no definite diagnosis (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) C. P. Zeller, M. D.

12-28-1930 (Address) Springfield Mo

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Reynolds Mortuary DATE OF BURIAL Dec 29 1930

20. UNDERTAKER J. H. Klingner & Co ADDRESS Springfield, Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

JAN 19 1931

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