

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

Do not use this space.

39130

File No. _____
Registered No. 974 _____
St. _____ Ward) _____

PLACE OF DEATH

County Greene Registration District No. 318
Township _____ Primary Registration District No. 2501
City Springfield (No. Baptist Hospital) _____ St. _____ Ward) _____

2. FULL NAME

(a) Residence. No. Cabool mo 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 7 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John Henderson

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 2 1882

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
48 6 26

8. OCCUPATION OF DECEASED

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

PARENTS

10. NAME OF FATHER Wm Hargis

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT John Henderson
(Address) Cabool mo

15. FILED 12 28 19 30 For Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12 28 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1930 to Dec 28 1930 that I last saw her alive on Dec 28 1930, and that death occurred, on the date stated above, at 9:10 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Exhaustion & Chronic Apprehension
55 1/2 (duration) yrs. 6 mos. ds.
CONTRIBUTORY Use of Medication (SECONDARY) (duration) 1 yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF Dec 19 30

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS Cholera
(Signed) W. Russell, M. D.
12/28/1930 (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 Cabool mo DATE OF BURIAL 12/28 1930

20. UNDERTAKER Alma Schmeyer ADDRESS 534 St Louis

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

