

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

Do not use this space.

951

File No. \_\_\_\_\_  
Registered No. 63  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**PLACE OF DEATH**

County Ireene Registration District No. 318  
Township \_\_\_\_\_ Primary Registration District No. 2001  
City Springfield (No. 1145) Chestnut

**2. FULL NAME**

(a) Residence. No. 1145 E. Chestnut 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) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 15 - 1854

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
76 5 6

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) Mo. (STATE OR COUNTRY)

10. NAME OF FATHER Thomas Young  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown  
12. MAIDEN NAME OF MOTHER Unknown  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown

14. INFORMANT Ed. J. Davis (Address) Springfield, Mo

15. FILED 1-22-1931 Tom Sharp REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 21 1931

I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_ that I last saw him alive on Jan 21, 1931, and that death occurred, on the date stated above, at 8:30 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Apopoplexy  
87.71 hr (duration) yrs. mos. ds.  
CONTRIBUTORY (SECONDARY) gaining consciousness (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED at home  
IF NOT AT PLACE OF DEATH \_\_\_\_\_  
DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? no  
WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_  
(Signed) Thomas C. Stone, Genl, M. D.  
Jan 21, 1931 (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 St. Albans Cemetery DATE OF BURIAL Jan 22, 1931  
20. UNDERTAKER W. Kingner & Co ADDRESS 4246. Rom  
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.

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

EB 18 1931  
5-3-31

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