

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

24 05/10/1931 use this space.

1. PLACE OF DEATH

County Jasper Registration District No. 318
 Township Springfield Primary Registration District No. 200 File No. 570
 City Springfield (No. 800 N. Prospect) (Springfield Hospital) Ward

2. FULL NAME

(a) Residence, No. 800 N. Prospect St., _____ Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 2 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 W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 17 1905

7. AGE YEARS 26 MONTHS 2 DAYS 12 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

13. NAME J.H. Johnson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

15. MAIDEN NAME Belle Arnold

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Clarence Myers
800 N. Prospect

18. BURIAL, CREMATION, OR REMOVAL PLACE Richland Mo. DATE 7-31

19. UNDERTAKER (ADDRESS) W.F. Sharp
Springfield Mo.

20. FILED 7-31 1931 W.F. Sharp Registrar.

3. MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-29, 1931

22. I HEREBY CERTIFY, That I attended deceased from 9:25, 1931, to 7-29, 1931

I last saw him alive on 7-29, 1931 Death is said to have occurred on the date stated above, at 3:55 m.

The principal cause of death and related causes of importance were as follows:

Pulmonary Embolus Date of onset 7-29

1378
111A

Other contributory causes of importance:

Self-poisoning
three weeks or more

Name of operation Laboratory Date of 7-29

What test confirmed diagnosis? Injury Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? No Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____
(Signed) W.F. Sharp, M. D.

(Address) Springfield Mo.

WRITE PLAINLY, WITH UNFADING INK---FILL IN SPACES

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.

AUG 26 1931

State should be stated by the PHYSICIAN should state
S raised. Practise should be stated by the PHYSICIAN should state

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 318
 Township..... Primary Registration District No. 2001
 City Springfield (No. St. Ward)

File No.
 Registered No. 570

2. FULL NAME

Ethel Grace Myers
 (a) Residence, No. 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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

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

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

OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19...

19. UNDERTAKER (ADDRESS)

20. FILED 7-31 1931 Gon Sharp Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 29, 1931

22. I HEREBY CERTIFY, That I attended deceased from

..... to 19.....
 I last saw h..... alive on 19..... Death is said to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

Pulmonary Embolus Date of onset

Other contributory causes of importance:

Palpitations non-palpitated

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide..... Date of injury..... 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed)....., M. D.

(Address).....

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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.

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