

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

Do not use this space.

34207

1. PLACE OF DEATH

County Greene
Township Springfield
City Springfield

Registration District No. 318
Primary Registration District No. 2001

File No. 774
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 808 N. Talmadge 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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 24 1853

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>78</u>	<u>2</u>	<u>4</u>	

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

13. NAME Unknown

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

15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Hellie Workman Chicago Ill

18. BURIAL, CREMATION, OR REMOVAL PLACE Rollview Cemetery DATE Oct 29 1931

19. UNDERTAKER (ADDRESS) Worthing & Co Springfield Mo

20. FILED 10-26 1931 For Sharp Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 28 1931

22. I HEREBY CERTIFY, That I attended deceased from Sept 20 1931, to Oct 28 1931

I last saw him alive on Oct 21 1931 Death is said to have occurred on the date stated above, at 7 a.m.

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

Cancer of Liver
465 965
1186
163
Vomiting Incontinence
ascites

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? NO

If so, specify C. B. Watkins M.D.
(Signed) 318 1/2 College St (Address)

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.

NOV 24 1931

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