

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

Do not use this space.

St. Louis
40662
File No. _____
Registered No. **875**
St. _____ Ward _____

1. PLACE OF DEATH

County St. Louis Registration District No. 318
Township _____ Primary Registration District No. 5740
City Springfield (No. Route # 3) St. _____ Ward _____

2. FULL NAME

(a) Residence. No. Route # 3 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 _____ 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 14 1888

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
49 8 1

8. OCCUPATION OF DECEASED Stenographer
(a) Trade, profession, or particular kind of work
(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 Charles Daling

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

12. MAIDEN NAME OF MOTHER Gene Campbell

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

14. INFORMANT Everett Daling
(Address) Springfield Mo

15. FILED 1217 1931 Don Sharp
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 15 1931

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1931 to Dec 15 1931 that I last saw him alive on Dec 15 1931, and that death occurred, on the date stated above, at 8:10 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Valvular Heart disease
92A
1931 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Nephritis
(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? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical & Chemical Exam
(Signed) W. F. Wright M. D.

19/16 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 Forest Lawn DATE OF BURIAL 12-17 1931

20. UNDERTAKER Seaman Robinson ADDRESS Springfield

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.

