

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

Do not use this space.

1. PLACE OF DEATH

County Greene Registration District No. 378
 Township Campbell Primary Registration District No. 2001
 City Springfield (No. Springfield Hospital) St. _____ Ward _____

File No. 40679
 Registered No. 895

2. FULL NAME

Samuel Eganis
 (a) Residence. No. Argonia 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 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) Jan 1 - 1860

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
71 11 24

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farmer
 (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) Penn

10. NAME OF FATHER Daniel Eganis

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

12. MAIDEN NAME OF MOTHER Stuckey

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

14. INFORMANT (Address) Barker & Wheeler
Evanston Mo

15. FILED 12 25 19 31 Lon Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 25 19 31

17. I HEREBY CERTIFY, That I attended deceased from Dec 9, 1931, to Dec 25, 1931, that I last saw him alive on Dec 24, 1931, and that death occurred, on the date stated above, at 4 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute nephritis
108
130

CONTRIBUTORY (SECONDARY) Pneumonia - lobar (duration) yrs. mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED 108
 IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) Am J. Callaway, M. D.
 , 19 (Address) Springfield Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Ashegrove DATE OF BURIAL 12-27 19 31

20. UNDERTAKER Barker & Wheeler ADDRESS Evanston 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.

