

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

Do not use this space.

763
File No. _____
Registered No. 46
St. _____ Ward _____

1. PLACE OF DEATH

County Greene Registration District No. 318
Township Springfield Mo Primary Registration District No. 2014
City 609 W Chestnut

2. FULL NAME

(a) Residence. No. 609 W 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 Male 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 Annie Vandagriff

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 18 - 1853

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
78 2 28

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Widow
(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) Ky.

10. NAME OF FATHER

Wm Vandagriff

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Ky.

12. MAIDEN NAME OF MOTHER

Haley

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Ky.

14. INFORMATION

(Address) Springfield Mo

15. FILED

1-18-35

Wm Sharp
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-16-32

17. I HEREBY CERTIFY, That I attended deceased from 1-10-32 to 1-15-32 that I last saw him alive on 1-10-32 and that death occurred, on the date stated above, at _____

THE CAUSE OF DEATH WAS AS FOLLOWS:

Pericarditis with Effusion
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) arteriosclerosis
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) Wm Sharp M. D.

1-17-32 (Address) 450 1/2 E. Council

*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

Greenbawn Cemetery

DATE OF BURIAL

1/17 1932

20. UNDERTAKER

Bruce Lohmeyer

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.

FEB 24 1932

CAUSE
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applied. AGR

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