

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

Do not use this space.

798 *D. Tolson*

File No. _____
Registered No. 47 Ward _____

1. PLACE OF DEATH

County Springfield Registration District No. 318

Township 31 Primary Registration District No. 524 34

City Springfield Mo Route # 11 Greene Co. Mo (No. _____) (Ward _____)

2. FULL NAME

(a) Residence. No. RR # 11 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 Female 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 _____

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
about 75 - - -

8. OCCUPATION OF DECEASED

(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) (STATE OR COUNTRY) Unknown

10. NAME OF FATHER Unknown

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT (Address) Beatrice

15. FILED 1-18-32 Jon Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-16 1932

17. I HEREBY CERTIFY, That I attended deceased from 2-1, 1931, to 1-16, 1932 that I last saw her alive on 1-12, 1932 and that death occurred, on the date stated above, at 6:45 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senile Dementia
31 (duration) 3 yrs. - mos. - ds.
CONTRIBUTORY (SECONDARY) Chronic Nephritis
unknown (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

19. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? physical

(Signed) W. T. Water, M. D.

1-16 19 32 (Address) Springfield Mo

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) WHETHER ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

East Lawn 1/18 1932

20. UNDERTAKER ADDRESS

German Lutheran 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FILED 1-18-1932

