

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

Do not use this space.

15845

1. PLACE OF DEATH

County Greene Registration District No. 318

Township Springfield Primary Registration District No. 7001

City Springfield No. 1601 E. Haulsda St. St. _____ Ward) _____

File No. _____

Registered No. 343 _____

2. FULL NAME

(a) Residence, No. 1601 E. Haulsda 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 wn 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)

7. AGE YEARS 83 MONTHS 7 DAYS 21 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. grocer

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) Germany 10

FATHER 13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown 31

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT Henry Schamhart (ADDRESS) 1601 E. Haulsda

18. BURIAL, CREMATION, OR REMOVAL PLACE Greene DATE 5-8 32

19. UNDERTAKER John Thompson (ADDRESS) Springfield Mo

20. FILED 5/6 1932 John Thompson Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-6 1932

22. I HEREBY CERTIFY, That I attended deceased from Feb-13- 1932 to April 6- 1932

I last saw him alive on 5-6- 1932. Death is said

to have occurred on the date stated above, at 6 A. m.

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

Hypostatic pneumonia Date of onset 5-1-32
10 A
10 A
11 B

Other contributory causes of importance:
Trenchantia Trochlear Feb-12
of Sept 14y. of fever 32

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 _____

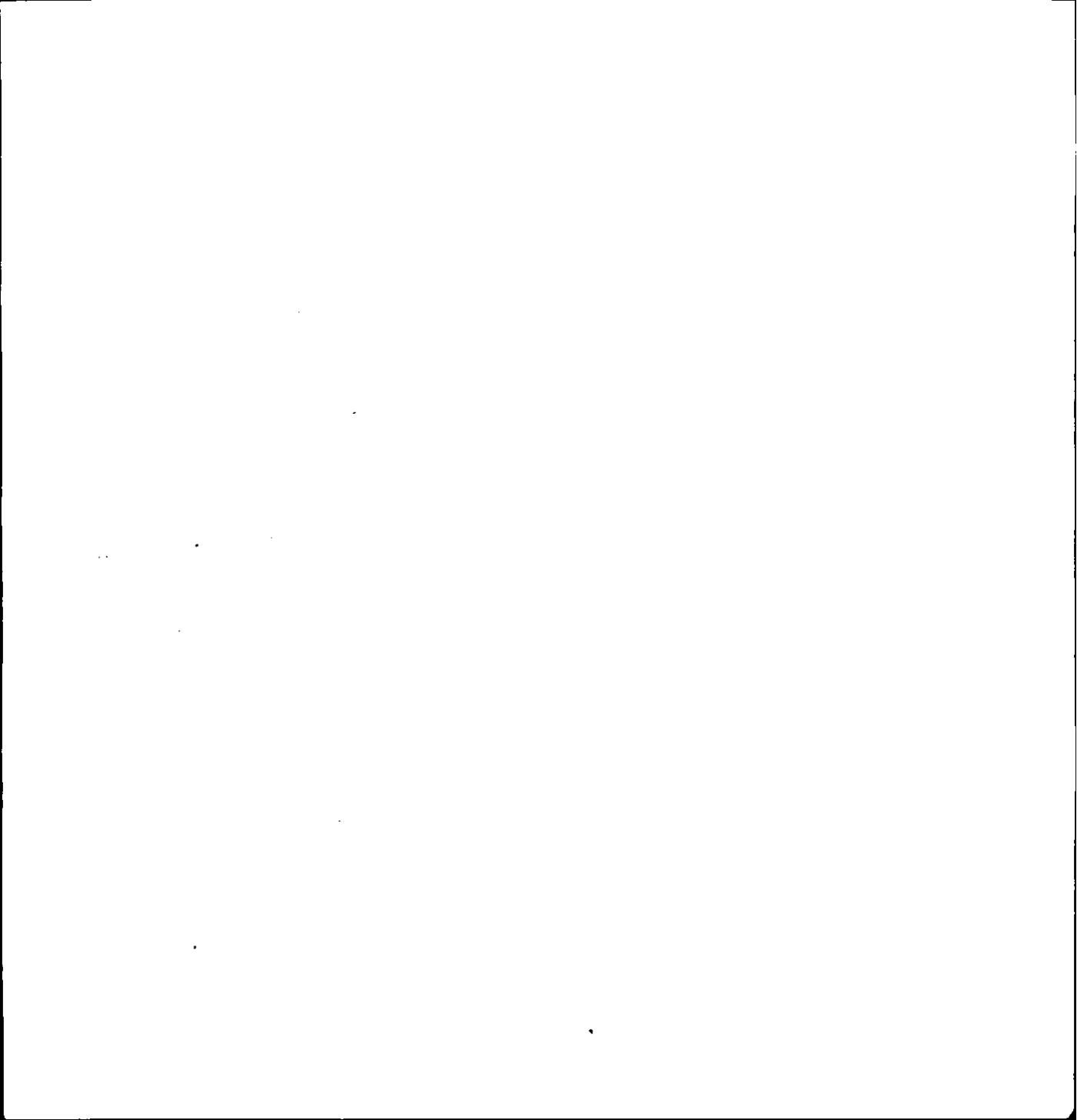
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) C. F. Zeller _____ M. D.

(Address) Springfield Mo



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Springfield Registration District No. 318
 Township _____ Primary Registration District No. 2001
 City Springfield No. _____ St. _____ Ward _____

2. FULL NAME

(a) Residence, 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED wid
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 15th 1848

7. AGE YEARS MONTHS DAYS If LESS than 1 day. hrs. min.
83 7 21

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19__

19. UNDERTAKER (ADDRESS)

20. FILED 7-6-30 Ralph W. King Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/6 1932

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19____. I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

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

Suppurative pneumonia Date of onset _____

Other contributory causes of importance:
Proximal fracture of left hip or femur

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? accident Date of injury 2-13, 1932

Where did injury occur? Springfield mo (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. at home tripped over rug while

Manner of injury walking from one room to another

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____ If so, specify _____

(Signed) _____, M. D.
 (Address) _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

5-15845