

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

Do not use this space.

*20 9157*

**1. PLACE OF DEATH**

County *Henry, Mo.* Registration District No. *318*  
 Township *Springfield No. 2* Primary Registration District No. *2001*  
 City *Springfield* (No. *27th*) John's St. Ward

File No. \_\_\_\_\_  
 Registered No. *201*  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. *RR 2 East of Springfield* 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**

**2 MEDICAL CERTIFICATE OF DEATH**

3 SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *March 2, 1933*

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

22. I HEREBY CERTIFY, That I attended deceased from *Feb 15, 1933, to March 2, 1933*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug 27, 1878*

I last saw h. *alive* on *March 1, 1933*. Death is said to have occurred on the date stated above, at *5 a. m.*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *56 6 10*

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

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

*Meningitis, Pyogenic (Probably streptococci)*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_

*8913*

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

Other contributory causes of importance: *Chronic Mastoid suppuration*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Springfield Mo*

Name of operation *Mastoid* Date of *2-17-33*

13. NAME *Joseph Thompson*

What test confirmed diagnosis? *Spinal fluid* Was there an autopsy? *ye*

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

15. MARRIED TO *Robert*

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

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

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

17. INFORMANT (ADDRESS) *Joseph Thompson*

Manner of injury \_\_\_\_\_ Nature of injury \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL *Springfield Mo* DATE *Mar. 3, 1933*

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

19. UNDERTAKER (ADDRESS) *Springfield Mo*

If so, specify \_\_\_\_\_ (Signed) *Thompson*, M. D.

20. FILED *3-3-33* *Ralph W. Langston* Registrar

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

APR 27 1933

