

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

J. H. Jullien
Do not use this space.

1. PLACE OF DEATH

County Greene Registration District No. 318 File No. 16277
 Township Springfield Primary Registration District No. 200 Registered No. 403
 City (No. 1920 N. Missouri St. _____ Ward)

2. FULL NAME

(a) Residence, No. 1920 N. Missouri Ward. (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 (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 7 - 1878

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
54 10 10

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

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) Harrington, Maine

13. NAME Robert

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

15. MAIDEN NAME Amanda

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

17. INFORMANT Margaret Fickett
 (ADDRESS) Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Mary's DATE 5/19 1935

19. UNDERTAKER J. H. Kolmayer
 (ADDRESS) Springfield, Mo.

20. FILED 5-19-35 1935 Ralph W. Langston
 Registrar

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5/17 1935

22. I HEREBY CERTIFY, That I attended deceased from April 15, 1933, to May 17, 1933

I last saw him alive on May 16, 1933 Death is said to have occurred on the date stated above, at 5:20 a m.

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

bar emom of
Luvin E. Steinhilber
4/15
4/15
4/15

Other contributory causes of importance: Sudden Al. Ueber

Name of operation Gastro Enterostomy Date of 1935

What test confirmed diagnosis? ago - 2 Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? no 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) J. H. Jullien, M. D.

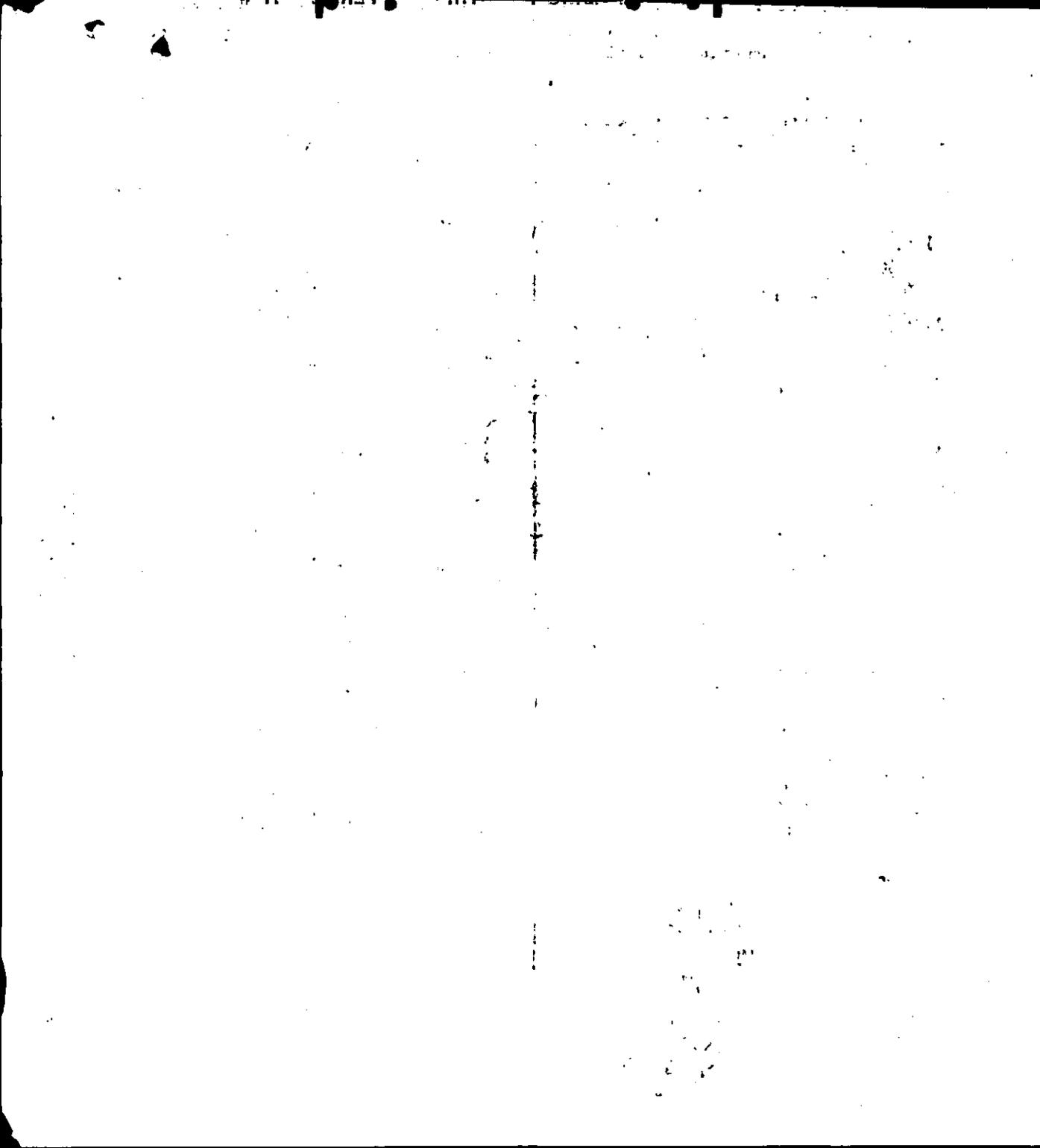
(Address) Springfield, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WIFE LEAVE WITH SPENDING INK—THIS IS A PERMANENT RECORD

JUN 22 1935

4321 80 81 82



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.

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

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Greene Registration District No. 318
Township Springfield 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 _____ 4. COLOR OR RACE _____ 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) _____

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

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

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

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 _____ 19 _____

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 17 1933

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:

Coronary artery disease
probable of slow
insidious nature
and atherosclerosis
Other contributory causes of importance: _____
hypertension
468

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) _____, M. D.
(Address) _____

SUPPLEMENTARY

COMMISSION OF STATE
 DEPARTMENT OF HEALTH
 DIVISION OF PUBLIC HEALTH

STATE OF NEW YORK
 DEPARTMENT OF HEALTH
 DIVISION OF PUBLIC HEALTH
 BUREAU OF VETERINARY MEDICINE
 ALBANY, N. Y.

MEDICAL CERTIFICATE OF DEATH

NO. 1 HERBY COLLIER, JR. 1914
 DEATH OF DEATH (CERTIFICATE NO. 1)
 I, the undersigned, being a duly qualified physician, do hereby certify that the above-named person died on the 1st day of 1914, at the residence of the deceased, in the town of ... county of ... State of New York, at the age of ... years, ... months, ... days, ... hours, ... minutes, ... seconds, of ...

STATISTICAL PARTICULARS

AGE AT DEATH ...
 SEX ...
 OCCUPATION ...
 CAUSE OF DEATH ...
 MANNER OF DEATH ...

5-1677-1-5

DEPARTMENT OF HEALTH
 DIVISION OF PUBLIC HEALTH
 BUREAU OF VETERINARY MEDICINE
 ALBANY, N. Y.

DEPARTMENT OF HEALTH, DIVISION OF PUBLIC HEALTH, BUREAU OF VETERINARY MEDICINE, ALBANY, N. Y.

DEPARTMENT OF HEALTH, DIVISION OF PUBLIC HEALTH, BUREAU OF VETERINARY MEDICINE, ALBANY, N. Y.