

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

OCT 20 1933

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

Fisco.
Do not use this space.

29335

1. PLACE OF DEATH

County Greene
Township Springfield
City Springfield

Registration District No. 318
Primary Registration District No. 200 Hospital
(No. St. Johns Hospital)

File No. _____
Registered No. 641
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 2005 N. Fort St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Katie Thomsen

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 19 - 1859

7. AGE YEARS 73 MONTHS 8 DAYS 20 If LESS than 1 day, _____ hrs. or _____ min.

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

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. P. R. Service

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

13. NAME Jurgen Thomsen

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

15. MAIDEN NAME Matta Kristine Simpson

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

17. INFORMANT (ADDRESS) Katie Thomsen Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Clear Creek Cemetery DATE Sep 11 1933

19. UNDERTAKER (ADDRESS) W. H. Wagner & Co. Springfield, Mo.

20. FILED 9/11/33 Ralph Vaughan Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-9-1933

22. I HEREBY CERTIFY, that I attended deceased from Sept 4, 1933, to Sept 9, 1933. I last saw him alive on Sept 9, 1933. Death is said to have occurred on the date stated above, at 3 P. m.

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

Central hemorrhage. Sept 2
Respiratory Failure
Other contributory causes of importance: _____

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? NO
If so, specify _____

(Signed) R. M. Reamy M. D.
(Address) 92 B. K. Main Springfield, Mo.

