

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.

34 1934

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

Do not use this space.

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1. PLACE OF DEATH

County Greene Registration District No. 318 File No. _____
Township _____ Primary Registration District No. 2001 Registered No. 114
City Springfield, Mo. (No. 915) Calhoun St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 915 Calhoun St., _____ 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 <u>Female</u>	4. COLOR OR RACE <u>white</u>	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) <u>Sept 24-1932</u>			
7. AGE	YEARS	MONTHS	DAYS
	<u>1</u>	<u>4</u>	<u>20</u>
If LESS than 1 day, _____ hrs. or _____ min.			
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>child</u>		
	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) <u>Springfield, Mo.</u>			
FATHER	13. NAME <u>Fred Brayfield</u>		
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>		
MOTHER	15. MAIDEN NAME <u>Viola Luedow</u>		
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Mo.</u>		
17. INFORMANT (ADDRESS) <u>Fred Brayfield 915 Calhoun</u>			
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Rayssville</u> DATE <u>Feb 16 1934</u>			
19. UNDERTAKER (ADDRESS) <u>Alman Lammeyer Springfield, Mo.</u>			
20. FILED <u>716</u> BY <u>W. B. Harmon</u> Registrar.			

MEDICAL CERTIFICATE OF DEATH

1. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 14 1934

2. I HEREBY CERTIFY, That I attended deceased from 2-9-1934 to 2-14-1934

I last saw him alive on Feb 14 1934 Death is said to have occurred on the date stated above, at 7:30 a.m.

The principal cause of death and related causes of importance were as follows:
Capillary Bronchitis Date of onset 2-7-34

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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?
If so, specify _____

(Signed) W. B. Harmon, M. D.
(Address) Springfield Mo.

