

MAY 25 1934

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

Do not use this space.

Dr. Wright
12570
173

1. PLACE OF DEATH

County Greene Registration District No. 314
Township Springfield Mo. Primary Registration District No. 1001
City Springfield Mo. No. 410 E. Monroe St. Ward

2. FULL NAME

(a) Residence, No. 410 E. Monroe Ward. 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 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 Wife

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 1934

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
86 7 ✓

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Contractor
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Contractor
10. Date deceased last worked at this occupation (month and year) Sept. 1934 11. Total time (years) spent in this occupation 108

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

MOTHER FATHER 13. NAME Dean

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

15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Dr. Wright

18. BURIAL, CREMATION, OR REMOVAL PLACE Maple Hill DATE April 3, 1934

19. UNDERTAKER (ADDRESS) Springfield Mo.

20. FILED 3-23 1934 Springfield Mo.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 21, 1934

22. I HEREBY CERTIFY, That I attended deceased from April 19, 1934 to April 21, 1934
I last saw him alive on 4/21, 1934 Death is said to have occurred on the date stated above, at 8:20 P.M.
The principal cause of death and related causes of importance were as follows:
Labor Pneumonia Date of onset 108

Other contributory causes of importance:
108

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? no

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) Dr. Wright, M. D.
(Address) Springfield Mo.

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.

any form of information should be carefully reviewed. The information should be checked EXACTLY. PHYSICIAN
in terms of what it may be. The information should be checked EXACTLY. PHYSICIAN

**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 (No.)

Primary Registration District No. 2001

File No.

Registered No. 173

St. Ward

2. FULL NAME

Tom Dean

(a) Residence, No. 410 S. Monroe St. Ward.

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 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) Sept 1847

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>86</u>	<u>7</u>	<u>unknown</u>	

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.....

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 21, 1934

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:

Date of onset

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) , M. D.

(Address)

SUPPLEMENTARY

Halbert Johnston

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

Every item of information 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.

S-12570