

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

Do not use this space.

16370

1. PLACE OF DEATH

County *Greene*
Township *Springfield*
City *Springfield* (No. *2220 Keltett*)

Registration District No. *318*
Primary Registration District No. *2001*

File No. *203*
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. *2220 Keltett* 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 *Female* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *single*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sep 5 - 1929*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
4 7 29

OCCUPATION

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

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *at home*

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) *Mo*

MOTHER FATHER

13. NAME *Homer A. Sheridan*

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

15. MAIDEN NAME *Viola Burgess*

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

17. INFORMANT *Homer A. Sheridan* (ADDRESS) *Springfield, Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Springfield* DATE *May 6 1934*

19. UNDERTAKER (ADDRESS) *W. W. King & Co. Springfield, Mo.*

20. FILED *5-5 1934*

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *5-4-1934*

22. I HEREBY CERTIFY, That I attended deceased from *4-10-1934* to *5-4-1934*

I last saw him alive on *5-3-1934* 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:

Meningitis - Th Date of onset *4-23-34*

24H

11B

Other contributory causes of importance:

Intestinal Infection

Name of operation _____ Date of _____

What test confirmed diagnosis *Smear* 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) *O. E. Zeller*, M. D.

(Address) *Springfield, Mo.*

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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.

