

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

Do not use this space.

16420

1. PLACE OF DEATH

County Greene
Township Springfield
City Springfield (No. Springfield Baptist Hosp)

Registration District No. 318 ✓
Primary Registration District No. 2081
File No. _____
Registered No. 219 Ward

2. FULL NAME

(a) Residence, No. Medred Garner Buffalo, Mo.

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 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 Geo Garner

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug-13-1907

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
26 9 13

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife
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) Dallas Tex

FATHER 13. NAME J.P. Cox

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Fair Grove Mo.

MOTHER 15. MAIDEN NAME Jessie Garner

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dallas Tex

17. INFORMANT (ADDRESS) J.P. Cox Buffalo Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Pleasant Ridge DATE 5-20-24

19. UNDERTAKER (ADDRESS) L. Brown Buffalo Mo.

20. FILED 5/30 1934 Ralph W Langston Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-29-1934

22. I HEREBY CERTIFY, That I attended deceased from May 22 1934 to May 29 1934
I last saw her alive on May 29 1934. Death is said to have occurred on the date stated above, at 12 p.m.
The principal cause of death and related causes of importance were as follows:

Date of onset

General Impair blood stream infection
Staphylococcus albous 12/5/34

Other contributory causes of importance: Toxemia

Name of operation _____ Date of _____
What test confirmed diagnosis? Blood culture primary test 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.

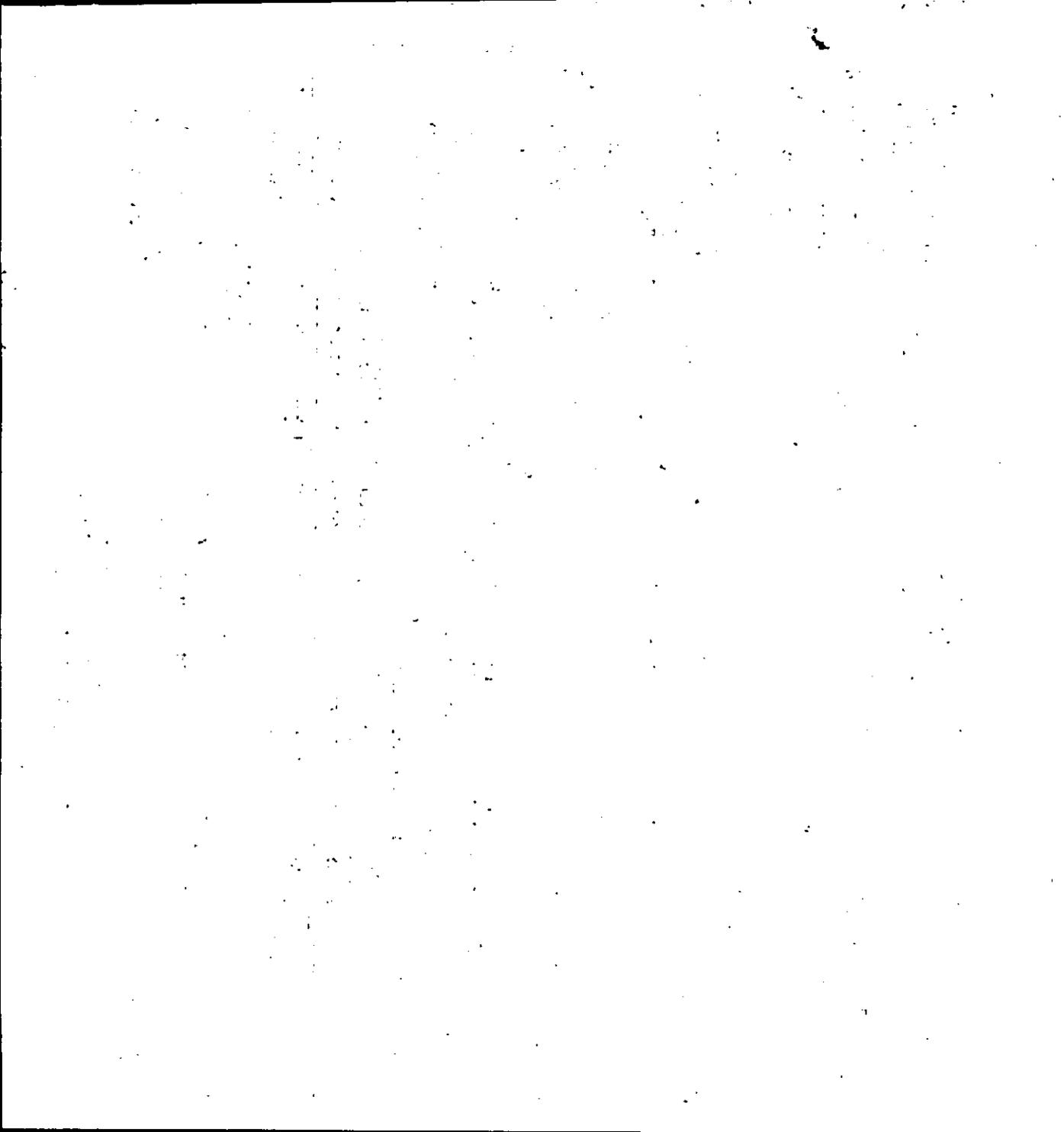
Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____

(Signed) A. Anderson M. D.
Levo Medical Arts Bldg
Springfield Mo

JUN 21 1934

CAUSE OF DEATH in plain terms, so that it may be properly classified.



DR. A. L. ANDERSON
SIXTH FLOOR, MEDICAL ARTS BUILDING
SPRINGFIELD, MO.

March 15, 1935.

Special Agent,
United States Bureau of the Census,
Jefferson City, Missouri.

Dear Sir:

In regard to the death notice enclosed #16420, register #203-?- will say that I thought I had made the report plain but in going over the records I find this patient came into the Springfield Hospital May 24th, 1934, and died May 29th, 1934.

Her history was that about two months prior to going to hospital she became ill with fever and one month before coming to the hospital gave prema-
ture birth which was supposed to be about eight months advanced. Just when and how she received this blood stream infection I am unable to state either do I know of any way of finding out the same, however, we did a blood culture on her as we suspected blood stream infection from her symptoms and found growth of staphylococcus albus. Her blood was grouped and blood transfusion given. Patient died.

I feel sure that I have done more in trying to arrive at a correct diagnosis in this case than is very often done and I do not think the department at Washington should be over duly exercised concerning this report.

Hoping this explanation will be satisfactory, I remain

Yours very truly,

Dr. A.L. Anderson.

A/S.

Encl.

S-126420

**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

File No. 16420

Township Springfield

Primary Registration District No. 2001

Registered No. 209-

City Springfield (No. Sp. g. Baptist Hosp. St. _____ Ward)

2. FULL NAME

(a) Residence, No. Buffalo Mrs. 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

MEDICAL CERTIFICATE OF DEATH

3. SEX

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

m -

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.

OCCUPATION

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.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May - 29, 1934

22. I HEREBY CERTIFY, That I attended deceased from

May 24, 1934, to May 29, 1934

I last saw him alive on May 28, 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:

Gen. Pepsis blood -
Strep infection -
Staphylococcus alb.
Septicemia

Date of onset

Other contributory causes of importance:

Name of operation

Date of

What test confirmed diagnosis? Alfred culture 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) A. P. Anderson, M. D.

(Address) 600 Med Arts

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY UNDERSTOOD.

5-16420