

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.

NOV 14 1934

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

Do not use this space.

35722  
528

1. PLACE OF DEATH

County Greene

Registration District No. 319

File No. \_\_\_\_\_

Township \_\_\_\_\_

Primary Registration District No. 2001

Registered No. \_\_\_\_\_

City Springfield (No. 963)

Pythian

St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME

(a) Residence, No. 963 Pythian 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-28, 1934

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

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 24-1934

I last saw him/her dead between 10-28, 1934 Death is said

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

to have occurred on the date stated above, at 12 m.

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

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

States dyspepsia Date of onset \_\_\_\_\_

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

Other contributory causes of importance \_\_\_\_\_

13. NAME Robert Nell

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

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

What test confirmed diagnosis? None Was there an autopsy? No

15. MAIDEN NAME Loris M. Woodson

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

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

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

17. INFORMANT (ADDRESS) Robert Nell Mo. Springfield

Specify whether injury occurred in industry, in home, or in public place.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Charles Cemetery DATE Oct 28, 1934

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

19. UNDERTAKER (ADDRESS) W. H. Wagner Mo. Springfield

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify \_\_\_\_\_

20. FILED 10-28, 1934 Robert Nell

(Signed) Chas. L. George - Crown M.D.

(Address) Springfield Mo

