

JAN 7 1935

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

Do not use this space.

42607

1. PLACE OF DEATH

County Green Registration District No. 318
Township Springfield Primary Registration District No. 2001
City Springfield (No. 2185) Ill. Louis St St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 669 Delmar 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 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 Bernice Cahill

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 15-1876

7. AGE YEARS 58 MONTHS 8 DAYS 27 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Bank Liquidator

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. In office

10. Date deceased last worked at this occupation (month and year) Dec 12-1934 11. Total time (years) spent in this occupation ✓

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

13. NAME Abner Cahill

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

15. MAIDEN NAME Unknown

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

17. INFORMANT Bernice Cahill (ADDRESS) Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Maplebrook DATE Dec-15- 1934

19. UNDERTAKER (ADDRESS) W. R. Kingery & Co. Springfield, Mo.

20. FILED 12-1- 1934 Springfield

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/12 1934

22. I HEREBY CERTIFY, That I attended deceased from 12/12 only, 1934 to _____, 19____

I last saw him alive on 12/12, 1934. Death is said

to have occurred on the date stated above, at 3:30 p.m.

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

Angina pectoris Date of onset 12/A 1934

Other contributory causes of importance None

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) H. B. Lemmon M. D.

(Address) _____ SPRINGFIELD, MO.

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.

