

JAN 12 1934

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

Do not use this space.

42610

1. PLACE OF DEATH

County *Greene*
Township *Springfield*
City *Springfield* (No. *1944*)

Registration District No. *318*
Primary Registration District No. *201*
1-Pickwick

File No. *607*
Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. *1944 N-Pickwick* 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) *single*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *March 15-1933*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____hrs. or _____min.
1 8 27

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

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.*

13. NAME *O. H. Plumb*

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

15. MAIDEN NAME *Anna M. Cooper*

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

17. INFORMANT *O. H. Plumb* (ADDRESS) *Springfield, Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Green Lawn Cemetery* DATE *Dec 13, 1934*

19. UNDERTAKER (ADDRESS) *W. T. Angerer, 5 Co., Springfield, Mo.*

20. FILED *12-13* 1934

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec. 12* 19*34*

22. I HEREBY CERTIFY, That I attended deceased from *Dec. 4* 19*34*, to *Dec. 12* 19*34*

I last saw him alive on *Dec. 11* 19*34* 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:

*11 P
12 P
13 P
14 P
15 P
16 P
17 P
18 P
19 P
20 P
21 P
22 P
23 P
24 P
25 P
26 P
27 P
28 P
29 P
30 P
31 P
32 P
33 P
34 P
35 P
36 P
37 P
38 P
39 P
40 P
41 P
42 P
43 P
44 P
45 P
46 P
47 P
48 P
49 P
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51 P
52 P
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62 P
63 P
64 P
65 P
66 P
67 P
68 P
69 P
70 P
71 P
72 P
73 P
74 P
75 P
76 P
77 P
78 P
79 P
80 P
81 P
82 P
83 P
84 P
85 P
86 P
87 P
88 P
89 P
90 P
91 P
92 P
93 P
94 P
95 P
96 P
97 P
98 P
99 P
100 P*
Prosecho-pneumonia

Other contributory causes of importance:

*Influenza
Acute Toxicity*

Name of operation _____ Date of _____
What test confirmed diagnosis *clinical* 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) *Arthur D. Knack* _____ M. D.

(Address) *459 1/2 E. Canal 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.

