

JAN 2 1935

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

Do not use this space.

42614

File No. 609  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

1. PLACE OF DEATH

County Greene  
Township Springfield  
City Springfield (No. 1979)

Registration District No. 318  
Primary Registration District No. 2004  
Shade Ave

2. FULL NAME

(a) Residence, No. 1979 Shade Ave 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<br><u>Female</u>                                               | 4. COLOR OR RACE<br><u>white</u> | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)<br><u>single</u> |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>✓</u> |                                  |                                                                            |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb. 14 - 1932</u>         |                                  |                                                                            |
| 7. AGE                                                                | YEARS<br><u>2</u>                | MONTHS<br><u>9</u>                                                         |
|                                                                       | DAYS<br><u>29</u>                | If LESS than 1 day, _____ hrs. or _____ min.                               |

|            |                                                                                                             |
|------------|-------------------------------------------------------------------------------------------------------------|
| OCCUPATION | 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.<br><u>child</u> |
|            | 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.<br><u>at Home</u>        |
|            | 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) Arkansas

13. NAME Clarence E. Albert

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

15. MAIDEN NAME Josephine Cooper

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

17. INFORMANT Clarence E. Albert  
(ADDRESS) Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL Brick Church  
PLACE DATE Dec 14 1934

19. UNDERTAKER Funkhouser & Co.  
(ADDRESS) Springfield, Mo.

20. FILED 12 - 13 1934

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-13 1934

22. I HEREBY CERTIFY, That I attended deceased from Dec 4 1934, to Dec 13 1934

I last saw him alive on Dec 11 1934. Death is said to have occurred on the date stated above, at 4.9 a.m.

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

Pneumonia (Lobar)  
Double Otitis Media  
Other contributory causes of importance: none

Name of operation none Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ 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? No

If so, specify \_\_\_\_\_ (Signed) J. H. Harrison M. D.

(Address) Springfield, Mo.

