

Jan 2 1935

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

Do not use this space.

42636

File No. 629
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH

County Greene
Township Springfield
City Springfield (No. 2525)

Registration District No. 318
Primary Registration District No. 2001
N. Broadway

2. FULL NAME

(a) Residence, No. 2525 N. Broadway St. _____ Ward _____
(Usual place of abode)

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 13 - 1859

7. AGE YEARS 75 MONTHS 10 DAYS 7 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House Work
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 _____

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

MOTHER FATHER 13. NAME Schrader

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

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT Mrs. Horace B. Hicks (ADDRESS) Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Maple Park Cemetery DATE Dec 21 1934

19. UNDERTAKER (ADDRESS) J. W. Klingner & Co., Springfield, Mo.

20. FILED 12-20 1934 Not at all

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-20 1934

22. I HEREBY CERTIFY, That I attended deceased from Dec-15, 1934, to Dec-19, 1934

I last saw her alive on Dec-15, 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:

Cerebral Hemorrhage
Date of onset _____
Other contributory causes of importance _____
Name of operation _____ 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) Dr. G. B. South, M. D.
223 1/2

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.

