

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

Do not use this space.

As per
909
File No. 21
Registered No. _____
St. _____ Ward) _____

1. PLACE OF DEATH

County Greene Registration District No. 318
Township _____ Primary Registration District No. 450
City Springfield Mo. 1541 W. Phelps St. _____ Ward) _____

2. FULL NAME

(a) Residence, No. 1541 W. Phelps 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 Female 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 A. M.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 30 - 1874

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
58 8 13

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

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

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) Worth Mo.

13. NAME A. Watson

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

15. MAIDEN NAME Sarah Garrison

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

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE Waller's Chapel

19. UNDERTAKER (ADDRESS) Wm. Labmeyer

20. FILED 1-14 1935

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 13 - 1935

22. I HEREBY CERTIFY That I attended deceased from Dec 1 1934 to Jan 13 1935

I last saw her alive on Jan 8 1935. Death is said to have occurred on the date stated above, at 6 P. m.

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

Carcinoma of uterus ?

Other contributory causes of importance: 48

Name of operation _____ Date of _____

What test confirmed diagnosis? Time Exam 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. Knapp, M. D.

(Address) 450 1/2 E. Canal

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.

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