

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

55B 25 1935

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

Do not use this space.

948

1. PLACE OF DEATH *Greene*

County *Greene*  
Township *Springfield*  
City *Springfield* (No. *1540 N. Clay Ave.*)

Registration District No. *318*  
Primary Registration District No. *20th*

File No. *56*  
Registered No. *56*  
St. *Clay Ave.* Ward

2. FULL NAME *Frank A. Cordray*

(a) Residence, No. *1540 N. Clay 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 <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>married</i>
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Aug 6 - 1866</i>		
7. AGE	YEARS <i>68</i>	MONTHS <i>5</i>
	DAYS <i>19</i>	If LESS than 1 day, .....hrs. or .....min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Retired Real Estate Operator</i>	11. Total time (years) spent in this occupation <input checked="" type="checkbox"/>
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <i>In Office</i>	
FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Athens Ohio</i>	
	13. NAME <i>Thos. Cordray</i>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Unknown</i>	
MOTHER	15. MAIDEN NAME <i>Unknown</i>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Unknown</i>	
	17. INFORMANT (ADDRESS) <i>Nellie Cordray Springfield, Mo.</i>	
	18. BURIAL, CREMATION, OR REMOVAL PLACE <i>St. Marys Cemetery</i> DATE <i>Jan 8 1935</i>	
	19. UNDERTAKER (ADDRESS) <i>J. H. Kingery &amp; Co. Springfield, Mo.</i>	
	20. FILED <i>1-28 1935</i> Registrar <i>W. T. Walsh</i>	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *1-25 1935*

22. I HEREBY CERTIFY, That I attended deceased from *1-25 1935* to *1-25 1935*

I last saw him alive on *1-25 1935*. Death is said to have occurred on the date stated above, at *5 P. m.*

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

*Influenza* 1-18-35  
*Disseas of valves of heart and arteriosclerosis*

Other contributory causes of importance:  
*Disseas of valves of heart and arteriosclerosis*

Name of operation *none* Date of *Jan 25 1935*

What test confirmed diagnosis? *none* 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 *Jan 25 1935*

Where did injury occur? *Home* (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury *fall*  
Nature of injury *fall*

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify *W. T. Walsh, M. D. Springfield Mo.*

