

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.

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

Do not use this space.

APR 17 1935

48790

1. PLACE OF DEATH

County Greene

Registration District No. 318

File No. 152

Township Springfield Mo.

Primary Registration District No. 200

Register No. 152

City Springfield Mo.

Place of death Spring Hospital

Ward

2. FULL NAME

(a) Residence, No. 100 1/2 Locust
(Usual place of abode)

St. Locust

Ward

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 14, 1935

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

22. HEREBY CERTIFY, That I attended deceased from Mar. 9, 1935, to March 14, 1935

I last saw her alive on March 14, 1935. Death is said to have occurred on the date stated above, at 7:00 m.

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 1868

7. AGE

YEARS 66

MONTHS 4

DAYS unk

If LESS than 1 day, hrs. or min.

Date of onset 3/9/35

OCCUPATION

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

Lobar Pneumonia

Other contributory causes of importance:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Springfield Mo.

MOTHER FATHER

13. NAME Isaac Robinson

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

15. MAIDEN NAME Margaret Pence

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

17. INFORMANT (ADDRESS) Mrs Sarah Scott (K)

18. BURIAL, CREMATION, OR REMOVAL PLACE Rosemont Ave DATE March 11, 35

19. UNDERTAKER (ADDRESS) Springfield Mo.

20. FILED 3-16, 1935

Chr. pulmonary Tuberculosis

Name of operation Chloroform Date of 7

What test confirmed diagnosis? Chloroform 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 O. Knapp, M. D.

(Address) 440 1/2 E. 5th

Registrar

