

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

Do not use this space

8796

*Dr. Robert [Signature]*

APR 1 1935

**1. PLACE OF DEATH**

County *Illinois*

Registration District No. *318*

Township *Springfield*

Primary Registration District No. *9001*

City No. \_\_\_\_\_

File No. \_\_\_\_\_

Registered No. \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. \_\_\_\_\_

(Usual place of abode)

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

*Male*

4. COLOR OR RACE

*White*

5. SINGLE, MARRIED, WIDOWED, OR

*Single*

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

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

AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION

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

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)

FATHER

13. NAME

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

MOTHER

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE

19. UNDERTAKER (ADDRESS)

20. FILED

*3-19*

19*35*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Mar 16 35*

22. I HEREBY CERTIFY, That I attended deceased from *Mar 14 35* to *Mar 16 35*

I last saw him alive on *Mar 16 35*. Death is said to have occurred on the date stated above, at *10 p. m.*  
 The principal cause of death and related causes of importance were as follows:

*Pneumonia influenzal*  
*Loobar*

Other contributory causes of importance: *11a*

Date of onset

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*35*

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) *Robert Glynn*

M. D.

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.

