

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

Do not use this space.

OCT 23 1935

29235

1. PLACE OF DEATH

County Greene Registration District No. 318
 Township Campbell Primary Registration District No. 2001
 City or Village 1050 1/2 East

File No. _____
 Registered No. 407
 St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 1050 1/2 East St. _____ Ward _____
 (Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 25 - 1867

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hra. ormin.
68. 5. 10

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

FATHER 13. NAME William Taylor

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

MOTHER 15. MAIDEN NAME Warkhous

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

17. INFORMANT Mrs Edward Taylor
 (ADDRESS) 1050 1/2 East

18. BURIAL, CREMATION, OR REMOVAL PLACE Eastlawn DATE Sept 7, 1935

19. UNDERTAKER Floyd W. Gut
 (ADDRESS) 629 W. Walnut

20. FILED 9-7-35 Revdangston
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 5, 1935

22. I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1932, to Sept 5, 1935

I last saw him alive on Sept 1, 1935 Death is said to have occurred on the date stated above, at 12 p. m.

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

Chronic myocardial degeneration
Intermittent

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? _____
 If so, specify Robert Storm, M. D.
 (Signed) _____ (Address) Springfield Mo

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.

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

MAR 7 1946