

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.

OCT 23 1935

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

Do not use this space.

1. PLACE OF DEATH

County Greene Registration District No. 318
Township _____ Primary Registration District No. 2001
City Springfield Mo (No. 726 W. Union) _____ St. _____ Ward _____

File No. 29245
Registered No. 419

2. FULL NAME

Kathrine Davidson
(a) Residence, No. 726 W. Union St., _____ Ward _____
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Divorced</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>M. W. Davidson</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>April 22 1910</u>		
7. AGE	YEARS <u>25</u>	MONTHS <u>4</u>
	DAYS <u>18</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Home wife</u>	
	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) <u>Springfield Mo</u>		
FATHER	13. NAME <u>John W. Campbell</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Bathfield Green Bay Mo</u>	
MOTHER	15. MAIDEN NAME <u>Arminie Nolenberg</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Bathfield Mo</u>	
17. INFORMANT (ADDRESS) <u>John W. Campbell 1449 Bristol St</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Paterson Cemetery</u> DATE <u>Sept 12 1935</u>		
19. UNDERTAKER (ADDRESS) <u>T. C. Phime Springfield Mo</u>		
20. FILED <u>9-12-35</u> <u>R. W. Langston</u> Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 10 1935

22. I HEREBY CERTIFY, That I attended deceased from 7-30-35 19, to 9-10-35 19.

I last saw h. or alive on Sept 4-35 19. Death is said to have occurred on the date stated above, at 4:30 p. m.

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

Date of onset _____

Other contributory causes of importance:
Asphy

Name of operation _____ Date of _____

What test confirmed diagnosis Asphy 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? _____

If so, specify _____

(Signed) John Davidson, M. D.
(Address) Springfield

