

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

Do not use this space.

39227

FEB 3 1936

1. PLACE OF DEATH

County Greene Registration District No. 318 File No. _____
Township _____ Primary Registration District No. 2001 Registered No. 652
City Springfield (No. St. Johns Hospital) _____ Ward _____

2. FULL NAME

(a) Residence. No. 720 N. Grand _____ 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 Fe 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
42 unknown

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Virginia
(STATE OR COUNTRY)

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) unknown
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) unknown
(STATE OR COUNTRY)

14. INFORMANT Herschord
(Address)

15. FILED 12-1, 1935 R.W. Gage REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-1 19 35

17. I HEREBY CERTIFY, That I attended deceased from 11-5, 1935, to 12-1, 1935 that I last saw h. or alive on 11-30, 1935, and that death occurred, on the date stated above, at 3:45 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexitis

CONTRIBUTORY (SECONDARY) Electrolytic - sub-phrenic abscess

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? no DATE OF 11/18 & 11/30

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? opt

(Signed) W. H. Gage

, 19 (Address) Springfield Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

20. UNDERTAKER Thyane Dec 1 1935

Alma Lohmeyer ADDRESS Springfield

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.

WHILE PRINTING, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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