

FEB 19 1936

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

Do not use this space.

966

1. PLACE OF DEATH

County Greene
Township Springfield
City Springfield

Registration District No. 318
Primary Registration District No. 2091
1502 Washington

File No. _____
Registered No. 79
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 1502 Washington St. _____ 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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 16 - 1935

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
0 ✓ 13

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Infant
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. at Home
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) Mo.

FATHER

13. NAME Sebaugh M. Goodwin

MOTHER

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

15. MAIDEN NAME Mable Eva Atwood

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

17. INFORMANT (ADDRESS) Sebaugh M. Goodwin

18. BURIAL, CREMATION OR REMOVAL Green Lawn DATE Jan 31 1936

19. UNDERTAKER (ADDRESS) J. W. Maguire & Co

20. FILED 31 1936 Ralph W. Langston Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1 - 29 - 1936

22. I HEREBY CERTIFY, That I attended deceased from 1 - 28 - 1936, to 1 - 29 - 1936
I last saw him alive on 1 - 29 - 1936 Death is said to have occurred on the date stated above, at 8:30 m.

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

Malaria
followed by
bronchial pneumonia
primary cause

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? No
If so, specify _____
(Signed) W. H. H. H., M. D.

(Address) Springfield Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. FILL IN CHANGES SHOWING CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

