

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

Do not use this space.

26290

1. PLACE OF DEATH

County Greene

Registration District No. 318

Township Springfield

Primary Registration District No. 22001

City Springfield (No. 1)

Burge Hoop.

File No. _____

Registered No. 646

St. _____ Ward)

2. FULL NAME

(a) Residence, No. 1540 N. 6th 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 11-1872

7. AGE YEARS 64 MONTHS 4 DAYS 15 If LESS than 1 day, _____ hrs. or _____ min.

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

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. In 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) No.

13. NAME James M. Mahon

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

15. MAIDEN NAME Unknown

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

17. INFORMANT J. Helton (ADDRESS) Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Marys Cemetery DATE July 28, 1936

19. UNDERTAKER W. K. Robinson (ADDRESS) Springfield, Mo.

20. FILED 7-27-1936 BY Chas a George Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7/26, 1936

22. I HEREBY CERTIFY, That I attended deceased from 1-15, 1936 to 7-26, 1936

I last saw her alive on 7/25/36 Death is said to have occurred on the date stated above, at 3 P m.

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

Carcinoma of stomach, left Breast and Both lungs
Primary seat Breast
Disease of valves of heart

Name of operation _____ Date of _____
What test confirmed diagnosis? X Ray 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? No
If so, specify _____

(Signed) W. J. Watch, M. D.
(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.

