

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.

NOV 27 1936

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

Do not use this space.

37363

1. PLACE OF DEATH

County *De Witt*

Registration District No. *318*

File No.

Township *Springfield No. 2001*

Primary Registration District No. *2001*

Registered No. *834*

City *Springfield* (No. *Springfield* Registered)

St. \_\_\_\_\_ Ward)

2. FULL NAME

(a) Residence, No. *221 S. Meeker* St., \_\_\_\_\_ Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *3* 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 *Thos E. Haswell*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 24 - 1872*

7. AGE YEARS *64* MONTHS *2* DAYS *15* If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

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

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Housewife*

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) *Mass.*

13. NAME *John Tracy*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ind.*

15. MAIDEN NAME *Griffiths*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ind.*

17. INFORMANT *Thos Walter Haswell* (ADDRESS) *221 S Meeker*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Springfield* DATE *10-10-36*

19. UNDERTAKER *Thos W. Tracy* (ADDRESS) *229 W. Washington*

20. FILED *10/9* 19 *36* *Thos. Chas A. George* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct. 9*, 19*36*

22. I HEREBY CERTIFY, That I attended deceased from *Sept 26*, 19*36* to *Oct 9*, 19*36*. I last saw him alive on *Oct 8*, 19*36*. Death is said to have occurred on the date stated above, at *3:50* p.m.

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

*Typhoid fever 9/24/36*

Other contributory causes of importance: *Indigestion Hemorrhage*

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_ What test confirmed diagnosis? *Symptoms* 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) *J. D. Bruton*, M. D.

(Address) *Springfield*

