

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.

MAY 20 1937

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

Fitch
Do not use this space.

16365

1. PLACE OF DEATH *Greene*
County *Greene* Registration District No. *318*
Township *Springfield* Primary Registration District No. *2001* File No. *16365*
City *Springfield* (No. *George Hospital*) Registered No. *0341*
St. *Springfield* (Ward)

2. FULL NAME *Donald Wingo*
(a) Residence, No. *2108 East Ave.* Ward. (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) *Aug 6-1936*

7. AGE YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
<i>✓ 0</i>	<i>8</i>	<i>16</i>	<i>7</i>

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 *Jrd. Wingo*

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

MOTHER

15. MAIDEN NAME *Frances Niles*

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

17. INFORMANT *Frances Wingo*
(ADDRESS) *Springfield, Mo.*

18. BURIAL, CREMATION OR REMOVAL *East Spring* DATE *Apr. 24 1937*

19. UNDERTAKER *J. W. Winger & Co.*
(ADDRESS) *Springfield, Mo.*

20. FILED *Apr 22 1937* *Chas. A. Georgetown*
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *4/22*, 19 *37*

22. I HEREBY CERTIFY, That I attended deceased from *4/19*, 19 *37*, to *4/22*, 19 *37*
I last saw him alive on *4/22*, 19 *37* Death is said to have occurred on the date stated above, at *12:30 P.* m.
The principal cause of death and related causes of importance were as follows:
Lobar Pneumonia
Date of onset *4/17/37*

Other contributory causes of importance:
108

Name of operation *None* Date of *to*
What test confirmed diagnosis? *None* Was there an autopsy? *to*

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. May Fitch*, M. D.
(Address) *Springfield, Mo.*

