

OCT 22 1937

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

Do not use this space.

1. PLACE OF DEATH

County *Greene*  
Township *McCampbell*  
City *Springfield*

Registration District No. *318*  
Primary Registration District No. *2001 2*  
No. *1127* *Cuthbert*

File No. *34216*  
Registered No. *891*

2. FULL NAME

*Infant of James E. and Helen Choate*  
(a) Residence, No. *1127* *Pythian* St. Ward.

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *M* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Infant*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept 4, 1937*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*0 0 2*

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. *Infant*  
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) *Springfield Mo*

FATHER 13. NAME *James E Choate*

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

MOTHER 15. MAIDEN NAME *Helen Rose*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Bois D'arc*

17. INFORMANT (ADDRESS) *James E Choate 1127 Pythian St*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Geary Chapel* DATE *9-7-1937*

19. UNDERTAKER (ADDRESS) *W. Lloyd W. Fox 229 Pythian St*

20. FILED *Sept 7, 1937* *Chas. L. George* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 6 - 1937*

22. I HEREBY CERTIFY, That I attended deceased from *9-4-1937* to *9-6-1937*  
I last saw him alive on *9-6-1937* Death is said to have occurred on the date stated above, at *11:30 pm*.  
The principal cause of death and related causes of importance were as follows:

*Premature Birth*

Date of onset

Other contributory causes of importance:  
*159*

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  
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?  
If so, specify  
(Signed) *W. Lloyd W. Fox* M. D.  
(Address) *Springfield Mo*

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**1. PLACE OF DEATH**

County ..... Registration District No. .... File No. ....  
 Township ..... Primary Registration District No. .... Registered No. ....  
 City ..... (No. ....) St. .... Ward .....

**2. FULL NAME**

(a) Residence, No. .... 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 ..... 4. COLOR OR RACE ..... 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) .....

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ..... hrs. or ..... min.
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OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. ....	II. Total time (years) spent in this occupation.....
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ....	
	10. Date deceased last worked at this occupation (month and year) .....	

12. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) .....

13. NAME .....

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

15. MAIDEN NAME .....

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

17. INFORMANT ..... (ADDRESS) .....

18. BURIAL, CREMATION, OR REMOVAL .....

PLACE ..... DATE ..... 19.....

19. UNDERTAKER ..... (ADDRESS) .....

20. FILED ..... 19.....

Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) ..... 19.....

22. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at..... m.

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

Other contributory causes of importance:

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?  
 If so, specify .....  
 (Signed) ..... M. D.  
 (Address) .....

CERTIFICATE OF DEATH IS A PUBLIC RECORD AND SHOULD BE KEPT IN A SAFE PLACE TO PROTECT IT FROM LOSS OR DESTRUCTION. EXACT STATEMENT OF OCCURRENCE IS VERY IMPORTANT.