

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

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

Do not use this space.

DEC 17 1937

41249

1. PLACE OF DEATH

County Green

Registration District No. 318

Township

Primary Registration District No. 2001

City Springfield (No. Springfield Baptist Hospital)

File No. \_\_\_\_\_  
Registered No. 9-1049  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Gideon Estel G

(a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward N. 1st Mo  
(Usual place of abode)

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 male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 27, 1933  
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 4 8 6 \_\_\_\_\_  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Child  
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) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Chariton co Missouri  
13. NAME Gideon Estel G  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri  
15. MAIDEN NAME Flem-Faught  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Gideon Estel G N. 1st Mo  
18. BURIAL, CREMATION, OR REMOVAL PLACE McConnel. Cem DATE Nov 4 1937  
19. UNDERTAKER T.W. Maples (ADDRESS) Chas U. George

20. FILED Oct 4 1937 Chas U. George Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 3 1937  
22. I HEREBY CERTIFY, That I attended deceased from 10-3-37 to 10-3-37, 19\_\_\_\_  
I last saw him alive on 10-3-37, 19\_\_\_\_ Death is said to have occurred on the date stated above, at 6 P. m.

The principal cause of death and related causes of importance were as follows:  
Septicemia?  
Septic meningitis  
that epidemic  
Date of onset 11-2-37  
Other contributory causes of importance:  
Toxic Encephalitis

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? Yes  
If so, specify \_\_\_\_\_  
(Signed) Urban B. Beach, M. D.  
(Address) Springfield, Mo

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 11/19/01 BY 60322 UCBAW/STP

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

41249

Do not use this space.

Registered No. 1049

1. PLACE OF DEATH

(a) County Greene Registration District No. 318  
 (b) Township \_\_\_\_\_ Primary Registration District No. 2001  
 (c) City Springfield (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Widow, Estel J.  
 (a) Residence, No. \_\_\_\_\_ St.   
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) 8

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.  
4 8 6

OCCUPATION

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

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19 \_\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED

Feb 14 1938 Chas A. George  
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 3 1938

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:

Septicemia  
systemic  
not epidemic  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance: 11/3  
Septic - Encephalitis

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) Urban Emriel, M. D.

(Address) Springfield mo

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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