

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**

2826
Do not use this space.

1. PLACE OF DEATH

(a) County Green Registration District No. 315
 (b) Township N. Campbell Primary Registration District No. 2001 Registered No. 94
 (c) City Springfield (d) Street No. 1719 W. Calhoun 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. 7 mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME DONNIE S. NODGRASS 92

(a) Residence, No. 1719 West Calhoun St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 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)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
0 9 28

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Child
 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) Springfield Mo.

FATHER 13. NAME Rex Snodgrass

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

MOTHER 15. MAIDEN NAME Edna Hogan

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

17. INFORMANT (ADDRESS) Rex Snodgrass
1719 W. Calhoun

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE Haltown Mo. Jan 31, 1938

19. FUNERAL DIRECTOR (ADDRESS) T. W. Maples
Clayton Mo.

20. FILED Jan 31, 1938 Chas A. George Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 30, 1938

22. I HEREBY CERTIFY That I attended deceased from Jan 24, 1938, to Jan 30, 1938
 I last saw him alive on Jan 28, 1938 Death is said to have occurred on the date stated above, at 8:30 p.m.
 The principal cause of death and related causes of importance were as follows:

Branchial Abscession
MeningoCocci
 Other contributory causes of importance:
MeningoCocci

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) Henry F. Kerahk M. D.
 (Address) Springfield Mo.

RECEIVED

FEB 24 1938

BUREAU OF VITAL STATISTICS
MO. STATE BOARD OF HEALTH

STATEMENT BY LICENSED EMBALMER

I, No Embalming, Licensed Embalmer No.

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No.....or by....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)