

JUL 11 1939

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

22161
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 218
(b) Township SPRINGFIELD Primary Registration District No. 2001 Registered No. 523
(c) City SPRINGFIELD (d) Street No. 975 N Jefferson 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

(a) Residence, No. 975 N Jefferson St. (If nonresident, give city or town and State)
(Usual place of abode, if not correct address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) August 29 1877

7. AGE YEARS MONTHS DAYS 61 10 3 IF LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Salesman
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) Iowa

13. NAME John Tiede

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

15. MAIDEN NAME Emma (Wink)

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

17. INFORMANT (ADDRESS) Dixie Jean Hamilton
Kansas City Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Maple Park DATE June 29 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alma Johnson
Springfield Mo.

20. FILED June 28 1939 Chas A George Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 20, 1939

22. I HEREBY CERTIFY, That I attended deceased from 11-7-1938, to 6-26-1939

I last saw him alive on 6-26-1939 Death is said to have occurred on the date stated above, at 9:50 A.M.

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

Angina pectoris
Coronary Thrombosis
Date of onset 1935?

Other contributory causes of importance: none

Name of operation none Date of none
What test confirmed diagnosis? electrocardiogram

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. J. Quible M. D.
Sander (Address) Springfield, Mo.

WRITE PAINFULLY, 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.

1 X16403

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.)

If this body is not embalmed, above space should be left blank.

