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

Do not use this space.

31023

File No. 678

Registered No.

1. PLACE OF DEATH
County Greene Registration District No. 318
Township Springfield Primary Registration District No. 2001
City (No. 1316 W. Thomas St. Ward)

2. FULL NAME D Marzee Ed Zender

(a) Residence, No. 1316 W. Thomas St. Ward.
(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)

OCT 22 1931

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 20 - 1850

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	81	1	22	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. at Home

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. House Work

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 Matthew Wallis

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

MOTHER

15. MAIDEN NAME Sarah Jane Alsup

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

17. INFORMANT (ADDRESS) Joseph Zender Springfield Mo

18. BURIAL, CREMATION, OR REMOVAL Hillcrest Lawn Cemetery DATE Sept 13 1931

19. UNDERTAKER (ADDRESS) Klingner & Co Springfield Mo

20. FILED 9-12 1931 Jon D Sharp Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept - 12 1931

22. I HEREBY CERTIFY, That I attended deceased from Aug 11 1931 to Sept 12 1931

I last saw her alive on Sept 12 1931. Death is said to have occurred on the date stated above, at 4 A m.

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

	Date of onset
Fracture + Dislocation of right hip:	
18 B	
14 P	
162	
Other contributory causes of importance:	
Senile senility	

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? Hip injury Date of injury Aug 11 1931
Where did injury occur? Home Springfield Mo
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Home
Manner of injury Fall Thru Fracture
Nature of injury Fracture

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) W. D. Armstrong, M. D.
(Address) Springfield Mo

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECOR

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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

WRITE PLAINLY. ...ADING INK—THIS IS A PERMANENT RECORD

...item of information should be supplied. AGE should be stated EXACTLY. PHYSICIAN should state ...DEATH in plain terms, so it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH

County ..... Registration District No. 318 File No. .....

Township ..... Primary Registration District No. 2001 Registered No. 678

City Springfield (No. ..... St. ..... Ward)

2. FULL NAME Maryee E. Fenders

(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)
F	W	wid

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.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

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

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 9/12, 19 31 Lon Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/12 19 31

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at .....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Fracture & dislocation of right hip from fall at home
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) Shock Senility
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? P. O.
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D
....., 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

S-3102