

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

Do not use this space.

30085

1. PLACE OF DEATH

County Frank

Registration District No. 318

Township Springfield

Primary Registration District No. 2001

City Springfield

(No. 983 Johnson)

File No. _____
Registered No. 630
St. _____ Ward _____

2. FULL NAME

(a) Residence No. 983 Johnson St. _____ Ward _____

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IS MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF J. F. Webb

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 19 1879

7. AGE YEARS 48 MONTHS 2 DAYS 19 IF LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

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

PARENTS

10. NAME OF FATHER Richard Pigg

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

12. MAIDEN NAME OF MOTHER Mandy Pigg

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

14. INFORMANT J. F. Webb
(Address) 983 Johnson

15. FILED 10/15/27 REGISTRAR Octorst mds

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-15-27

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to 10-15-27 that I last saw h. her alive on 10-14-27, and that death occurred, on the date stated above, at 7 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chromoplexy

CONTRIBUTORY (SECONDARY) 7401

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) C. E. Fellen, M. D.
10/15/27 (Address) Springfield Mo

*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 Highlandville Mo DATE OF BURIAL 10-17-27

20. UNDERTAKER W. H. Pearce ADDRESS Highlandville 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.

